VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT

Standard Insurance Company
(503) 321-7000
Fax (800) 378-2403
Toll Free (800) 348-3226
900 SW Fifth Avenue
Portland, OR 97204-1282
Policy Number **645938-A**

COVERAGE RATES:

Monthly rates vary, See the insurance policy, Page 2

COVERAGE AMOUNTS:

Employee:

Increments of $25,000 up to 10x base salary to a max of $500,000 (whichever is less)

Spouse only: **This option not offered**

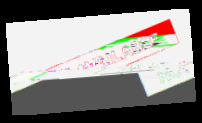
Up to 50% of employee coverage

Child(ren) only: **This option not offered**

Up to 10% of employee coverage, not to exceed $25,000

Spouse & Children:

Up to 40% of employee coverage; 5% of employee coverage per child



$.33 monthly per $1,000 of Member's AD&D insurance

Member only:

Member and Dependents:

$.050 monthly per $

Premium Due Dates:

January 1, 2008 and the first day of each calendar month thereafter.

Grace Period:

31 days

Standard Insurance Company **Enrollment and Change**

To Be Completed By Human Resources

Group Number	Division	Billing Category	Date of Employment
645938			

To Be Completed By Applicant

☐ Apply for Coverage ☐ Beneficiary Change ***Complete Beneficiary Section below.*** ☐ Name Change

☐ Add or ☐ Delete Dependent Date of add/delete _____

Your Name (Last, First, Middle)	Your Social Security Number	Birth Date	☐ Male ☐ Female	
Your Address		City	State	ZIP
Former Name (Last, First, Middle) *Complete only if name change*			Phone Number	
Employer Name **Wichita State University**			Job Title/Occupation	
Hours Worked Per Week	Earnings $_____ Per: ☐ Hour ☐ Week ☐ Month ☐ Year			

Coverage ***Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.***

Life Insurance

Voluntary Accidental Death and Dismemberment (AD&D) Insurance

☐ You only $_____ ☐ Your Spouse $_____ or _____% ☐ Your child(ren) $_____ or _____%

Beneficiary ***This designation applies to Accidental Death and Dismemberment (AD&D) Insurance available through your Employer, if any. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further information.***

Primary - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

Contingent - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

Signature I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.

Member/Employee Signature Required _____ Date (Mo/Day/Yr) _____

Return completed form to your Human Resources Department.

Beneficiary Information

x Your designation revokes all prior designations.

x