TheStandard
Positively different.

# Enrollment and Change Form

*Mark all boxes and complete all sections that apply. Return completed form to Human Resources.*

**APPLICANT**

| Your Name (Last, First, Middle) | Group Name **Town of Westford** | | Town or School Employee |
|---|---|---|---|
| Address | City | State | Zip |
| Social Security # | Date of Birth | Gender ☐ Male ☐ Female | Job Title/Occupation |

**INSURANCE**

*Check with your Human Resources/Benefits Department about coverage options available to you and Evidence of Insurability requirements.*

**Accident Insurance** (employee paid)

☐ Employee ☐ Employee and Children

☐ Employee and Spouse ☐ Employee and Family

**BENEFICIARY**

*This designation applies to Life, AD&D and Additional Life Insurance available through your Employer, if any. Designations are NOT valid unless signed, dated, and delivered to your Employer during your lifetime.*

| Primary- Full Name | Address | Social Security # | Relationship | % Benefit |
|---|---|---|---|---|
| | | | | |
| | | | | |
| Contingent- Fill Name | Address | Social Security # | Relationship | % Benefit |
| | | | | |
| | | | | |

**CHANGE**

***Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.***

☐ Beneficiary Change ☐ Other _____

**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 will change if my coverage or costs change.*

Member/Employee Signature Required Date (Mo/Day/YR)

**Human Resources/Benefits Department-** Complete this section. Retain form for your records

| Policy # | Date of Hire | Hours Worked Per Week | Earnings |
|---|---|---|---|
| 162241 | | | $_____ Per: ☐Hour ☐Week ☐Month ☐Year |