Reset

Standard Insurance Company

National Rural Letter Carriers' Association
Long Term Disability Plan
Enrollment and Change Form

☐ New ☐ Change

*Complete the NRLCA **LTD Enrollment Form** and either the **Direct Deposit PS Form 1199A or the Greater Insurance Service Payment Form 11-06** in this package. Mail the completed forms along with a photocopy of a current Earnings Statement (PS Form 1223) to the NRLCA Group Insurance Department in the envelope provided. Make sure you keep the pink copies of both the NRLCA LTD Enrollment and Change Form and Direct Deposit PS Form 1199A or the GIS PAID FORM 11-06 for your records.* ***Note: without a photocopy of your current Earnings Statement and the yellow and white copies of the Enrollment and Direct Deposit or Payment form we cannot process your enrollment. If you have any questions, please contact the Standard at 888-414-0383.***

APPLICANT

Your Name (Last, First, Middle)		Group Name **National Rural Letter Carriers' Association**	Group Number(s) **645536**	
Your Address		City	State	ZIP
Home Telephone No.	Post Office Address		Post Office Phone No.	
Date Appointed Regular/PTF Carrier	Annual Basic Salary		Route Evaluation Step	
Your Soc. Sec. No.	Date of Birth		☐ Male ☐ Female	

DISABILITY

Check with the NRLCA or The Standard about coverage options available to you and Evidence Of Insurability requirements.
Please check one box and fill in the cost per pay period below and on your PS Form 1199A, Part1, 5b, or on the GIS Form 11-06, as applicable.

Long Term Disability

Voluntary LTD

☐ Option 1 (50% of annual salary) ☐ Option 2 (60% of annual salary) ☐ Decline/Cancel Voluntary LTD Coverage

☐ Attached is my completed Allotment form. Cost Per Pay Period $_____

☐ Attached is my ACH debit authorization for Greater Insurance Services. Cost Per Month $_____

SIGNATURE

I wish to make the choices indicated on this form. If electing coverage, I authorize the United States Postal Service to make the appropriate 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. If declining coverage, I understand that if I want to become insured later, I will be required to provide The Standard with satisfactory Evidence Of Insurability, and that The Standard will have the right to refuse my request for insurance. I understand that coverage(s) not specifically elected will not become effective, even if not marked as declined above.

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

Plan Administrator - Complete this section. Retain form for your records.

Date of Hire/Rehire	Hrs. Worked Per Wk.	Earnings $_____ Per: ☐ Pay period ☐ Year

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National Rural Letter Carriers' Association – Group Insurance Department,
1630 Duke Street, 2nd Floor, Alexandria, VA 22314-3466