Pacific Guardian Life **Basic Plus**	**HSTA Voluntary Employees Beneficiary Association Trust Group Life Insurance Enrollment Application**

☐ **New** ☐ **Change** ☐ **Cancel**

Social Security #	Name (last, first, mi)		
HSTA-VEBA Trust ID#	Street Address		
☐ Male ☐ Female	City	State	Zip Code
Date of Birth / /	Home Telephone ( )	School/Work Telephone ( )	
Name of School	Date Employed	Date of Membership	Membership Type: ☐ **Active** ☐ **Retired**

I request the following HSTA Group Insurance coverage:

Coverage	Member	Spouse**		Dependent Child(ren)***(active only)
		Active	Retired	
Basic	☐	☐	☐	☐
Option 1	☐	☐		
Options 1 & 2	☐	☐		
Options 1, 2, & 3	☐	☐		
Options 1, 2, 3 & 4	☐	☐		
Additional Spouse*		☐		

Spouse/Dependent information:

Add	Delete	Spouse/Dependent Name	Birth Date	Social Security No.	Relationship
☐	☐				
☐	☐				
☐	☐				
☐	☐				
☐	☐				

NOTE: Spouse coverage may not exceed 50% of the coverage in force for the member.

* Additional Spouse coverage may be elected with any increment of coverage. (Active Members only)

** If your spouse is also a teacher, he/she cannot be covered as a dependent. Enrollment must be done separately. (Active & Retired Members)

*** Dependent children are eligible for coverage until age 19 or through age 22 but must be a full-time student attending an accredited school, college or university and dependent upon you for financial support. Student Certification is required for dependent children age 19 through 22. Annual student certification will be required. (Active Members only)

Beneficiary Information:

It is important that your beneficiary designation be clear so that there will be no question as to your meaning. The beneficiary designation may be changed at any time. The designation takes effect as of the date the completed form is received and accepted by HSTA Voluntary Employees Beneficiary Association Trust.

Beneficiary Name (last, first, mi)	Birth Date	Social Security No.	Relationship	Primary	Contingent
				☐	
				☐	☐
				☐	☐
				☐	☐
				☐	☐

I certify that the information provided is true and complete. I authorize HSTA-VEBA Trust to set the effective date of coverage and to make the deductions, adjustments or cancellations from my salary, wages, pension or other compensation for the monthly premium.

Employee Signature: _____ Date: _____

HSTA-VEBA Trust use	Effective/Change Date:	Termination Date:

This life insurance plan is underwritten by: Pacific Guardian Life Insurance Company, Limited

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