

Mark all boxes and complete all sections that apply. Return completed form to your Shelby County Employee Benefits Department.

APPLICANT	Name (Last, First, Middle)			Group Name Shelby County Government	Group Number(s) 642998-A	
	Address			City	State	ZIP
	Soc. Sec. No.	Date of Birth	Date of Hire	<input type="checkbox"/> Male <input type="checkbox"/> Female	Job Title	Department Name
ENROLL/CANCEL	Short Term Disability <input type="checkbox"/> Accept Voluntary STD <input type="checkbox"/> Decline Voluntary STD <input type="checkbox"/> I wish to cancel my current participation in Voluntary STD					
	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. I understand that coverage not specifically elected will not become effective, even if not marked as declined above.					
SIGNATURE	Member/Employee Signature Required				Date (Mo/Day/Yr)	
	Shelby County Employee Benefits Department use only.					
Effective Date				Input By		