

Please sign and return completed form to your district administrator.

FIRST NAME	INITIAL	LAST NAME
CTA MEMBER ID (Number is located on your CTA Membership card)	GROUP NAME California Teachers Association	
SCHOOL DISTRICT	BUILDING/WORK SITE	
<p>I acknowledge that effective September 1, 2007 all life and disability coverage that I have in effect with Unum on August 31, 2007 will transfer to The Standard.</p> <p>I authorize my employer to deduct premiums from my wages to cover my cost of insurance sponsored by California Teachers Association. I understand that my employer may provide updated payroll information to The Standard either periodically or at The Standard's request to ensure proper premium deductions are being made for my coverage. I understand that a copy of this form will be provided to my employer to facilitate payroll deduction for the coverages that I have elected. I understand that my premium deduction amount will change if my coverage or costs change.</p> <p>This authorization will remain in effect until cancelled by me or by The Standard. I certify that I am a member of California Teachers Association and understand that termination of CTA membership will cancel my coverage and deductions.</p>		
PARTICIPANT SIGNATURE _____ DATE _____		