Insurance Benefit Enrollment Form

Return to: National Insurance Services, Attn: Billing Department
250 S. Executive Drive, Suite 300 Brookfield, WI 53005-4273
Phone 1.800.627.3660 Fax 262.785.9269

A: Enter your information:

Employer Name: Millard Public Schools				NIS Group Number: 017208		
Full Name (Last name, First name, Middle Initial):				Date of Hire:		
Home Address:		City:		State:	Zip:	
Social Security Number:	☐ Single ☐ Married	U.S. Citizen? ☐ Yes ☐ No*		Date of Birth:	o Male o Female	
Occupation/Title:				Hours worked per week:	Annual Salary:	

*If you are not a U.S. Citizen, please provide a copy of your Visa.

Employer-Provided Insurance Benefits:

☑ Basic Life $50,000

B: Optional Insurance benefits: (see rate table)

☐ Elect	☐ Decline	**Employee Supplemental Life / AD&D Amount $________________________** $25,000 increments to a maximum of $300,000 not to exceed 5 times Annual Salary. *Evidence of Insurability is required for amounts over $150,000, late enrollees, or for increases in coverage.*
☐ Elect	☐ Decline	**Spouse Supplemental Life / AD&D Amount $__________________________** $12,500 increments to a maximum of $150,000 not to exceed 50% of the Employee's combined Basic and Supplemental Life amounts. **If elected, complete spouse information in section D** *Evidence of Insurability is required for amounts over $25,000, late enrollees, or for increases in coverage.*
☐ Elect	☐ Decline	**Child Supplemental Life $10,000** Live birth to age 19, or 23 if a full-time student **If elected, enter each child's information in section D** *Evidence of Insurability is required for late enrollees.*

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Full Name:	Employer Name: **Millard Public Schools**	Date:

Instructions for the employee: Complete, make a copy for your records and return the original form to your Benefits Administrator.
Instructions for assigning a Trust as your beneficiary: To name a trust as a beneficiary, indicate the name and date of the trust and the Trustee (show Name and address). Include a tax identification number if applicable.
Instructions for the Benefits Administrator: Retain a copy of this form for your records. Send the original to National Insurance Services.

C: Enter your Life Insurance Beneficiary information:

1. **Primary Beneficiary(ies)** Attach additional pages if necessary.

Full Name:	Relationship to you:	Date of Birth:	% of Benefit
Social Security Number:	Gender:	Address/Phone:	
Full Name:	Relationship to you:	Date of Birth:	% of Benefit
Social Security Number:	Gender:	Address/Phone:	
Full Name:	Relationship to you:	Date of Birth:	% of Benefit
Social Security Number:	Gender:	Address/Phone:	
Full Name:	Relationship to you:	Date of Birth:	% of Benefit
Social Security Number:	Gender:	Address/Phone:	

Total % of Benefit must equal 100%

2. **Secondary Beneficiary(ies)** Attach additional pages if necessary.

Full Name:	Relationship to you:	Date of Birth:	% of Benefit
Social Security Number:	Gender:	Address/Phone:	
Full Name:	Relationship to you:	Date of Birth:	% of Benefit
Social Security Number:	Gender:	Address/Phone:	
Full Name:	Relationship to you:	Date of Birth:	% of Benefit
Social Security Number:	Gender:	Address/Phone:	

Total % of Benefit must equal 100%

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Full Name:	Employer Name: **Millard Public Schools**	Date:

D: If Electing Additional Supplemental Life on Spouse/Child:

Full Name	Date of Birth	Social Security Number
Spouse		
Child		
Child		
Child		
Child		

Sign here (required whether electing or declining any coverage):

I have been given the opportunity to apply for group insurance and agree to accept or decline coverage(s) as noted above. If I am declining coverage(s), I understand that if my dependents or I decide to apply for coverage at a later date, Evidence of Insurability (medical questions) may be required at my own expense and the insurance company must approve coverage. If I have elected any coverage(s) above, I authorize my employer to make any required deductions, if any, from my salary to pay my portion of the insurance premium when my insurance becomes effective.

Warning: Any person who knowingly presents false information on an application for insurance may be guilty of a crime and subject to fines, confinement in prison, and/or denial of insurance benefits.

Signature:	Date:

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