Insurance Benefit Enrollment Form

Employee: Complete and return this form to your Benefits Administrator.

Benefits Administrator: Retain the original of this form for your records and provide employee with a copy. Mail a copy to:
National Insurance Services, Attn: Billing Department
300 N. Corporate Drive, Suite 300, Brookfield, WI 53045
Phone: 1.800.627.3660 Fax: 262.814.1397

All Eligible Employees

Enter your information:

Employer Name: **Independent School District 318 Grand Rapids**			NIS Group Number: **001074**	
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:	☐ Male ☐ Female
Occupation/Title:			Hours worked per week:	Annual Salary:

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

Insurance benefits:

Employer-Provided Insurance Benefits:		
☒ Basic Life and AD&D ☒ Long-Term Disability		
Optional Insurance Benefits:		
☐ Elect	☐ Decline	Employee Supplemental Life Amount $_____ $1,000 increments to a maximum of $150,000; minimum election of $10,000

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:

More on other side ----------→

Full Name:	Employer Name:	Date:

Enter your Life Insurance beneficiary information:

Primary Beneficiary(ies) Attach additional pages if necessary.		
Full Name:	Relationship to you:	% of Benefit
Full Name:	Relationship to you:	% of Benefit
Full Name:	Relationship to you:	% of Benefit
Secondary Beneficiary(ies) Attach additional pages if necessary.		
Full Name:	Relationship to you:	% of Benefit
Full Name:	Relationship to you:	% of Benefit
Full Name:	Relationship to you:	% of Benefit

Spouse's Signature (May be required if choosing a primary beneficiary other than your spouse. Under state law a beneficiary other than your spouse may not be honored unless your spouse signs below. Please consult with your legal advisor before making such a designation.)		
Spouse's Name:	Signature:	Date:

Sign here:

Signature:	Date:

Full Name:	Employer Name:	Date:

Rate Table:

Employee Supplemental Life Rates:

Age	Rate per $1,000 of Coverage
0-29	$0.04
30-34	$0.05
35-39	$0.07
40-44	$0.09
45-49	$0.15
50-54	$0.23
55-59	$0.41
60-64	$0.54
65-69	$1.00
70-74	$1.57
75+	$2.06

To calculate your Supplemental Life Supplemental Life premium:

_____/ $1,000 =_____x_____= $_____ Coverage Amount

Rate (See chart) Premium