Insurance Benefit Enrollment Form

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

NATIONAL INSURANCE SERVICES

Benefits Administrator: Retain a copy of this form for your records and provide employee with a copy. Mail original 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

Enter your information:

Employer Name: **Underwood ISD 550**			NIS Group Number: **001060**	
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:	Date Benefit Eligible:		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		
Optional Insurance Benefits:		
☐ Elect	☐ Decline	Supplemental Life and AD&D Amount $_____ • May elect either $10,000 or $20,000 (See rate table on Page 3 for Premium information) *May be subject to answer Medical Questions (Evidence of Insurability)*
☐ Elect	☐ Decline	Long-Term Disability (Class 04: Bus Drivers automatically enrolled) *Please see your Benefits Department for premium information

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: **Underwood ISD 550**	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:

More on next page

Full Name:	Employer Name: **Underwood ISD 550**	Date:

Rate Table: Employee Supplemental Life

Age	Monthly premium for $10,000 of coverage	Monthly premium for $20,000 of coverage
Under age 30	$0.61	$1.21
30-34	$0.71	$1.41
35-39	$1.01	$2.02
40-44	$1.31	$2.63
45-49	$2.02	$4.04
50-54	$3.13	$6.26
55-59	$5.66	$11.31
60-64	$7.88	$15.76
65	$11.62	$23.23
66	$12.73	$25.45
67	$14.34	$28.68
68	$15.86	$31.71
69	$17.57	$35.15
70	$19.49	$38.99
71	$21.41	$42.82
72	$23.63	$47.27
73	$25.86	$51.71
74	$27.98	$55.95
75 and over	$32.12	$64.24