

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



Enter your information:

Employer Name: Mitchell School District 17 2		NIS Group Number: 018350	
Full Name (Last name, First name, Middle Initial):		Date of Hire:	
Home Address:	City:	State:	Zip:
Social Security Number:	<input type="checkbox"/> Single <input type="checkbox"/> Married	U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No*	Date of Birth: <input type="checkbox"/> Male <input type="checkbox"/> 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:

Superintendent Administrator Teacher

Optional Insurance Benefits:

<input type="checkbox"/> Elect	<input type="checkbox"/> Decline	Long-Term Disability - Maximum Monthly Benefit* = \$9,167 Monthly Premium: _____ X \$0.0039 = _____ (Monthly Salary) (Monthly Premium*)
*This is meant to be an estimate only. Please refer to the Certificate for a full explanation of your plan's benefits, exclusions, limitations, deductible income or other reductions. Should there be any discrepancy between this form and the Certificate, the Certificate will prevail.		

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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Instructions for the employee: Complete and return this form to your Benefits Administrator.

Instructions for the Benefits Administrator: Retain a copy of this form for your records and provide employee with a copy. Mail original to National Insurance Services at the address above.

More on other side ----->

Full Name:	Employer Name: Mitchell School District 17 2	Date:
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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:
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Sign here:

Signature:	Date:
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