

Osseo Area Schools

Administered by National Insurance Services

Life/LTD Insurance Enrollment & Change

Employee ID

Group Number	School/Location	Contract Group	Date of Employment
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Choose
One

☐

Apply for Coverage

☐

Beneficiary Change

☐

Name Change

Name (Last, First, Middle)	Social Security Number	Date of Birth	
Address	City	State	Zip Code
Former Name (Last, First, Middle) <i>Complete only if name change</i>	Phone	<input type="checkbox"/> Male <input type="checkbox"/> Female	

Hours Worked Per Week	Earnings \$	per	<input type="checkbox"/> Hour	<input type="checkbox"/> Week	<input type="checkbox"/> Month	<input type="checkbox"/> Year
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Coverage

Check with the Human Resources Department about coverage options available to you.

Life Insurance

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Basic Life with AD&D (Employer Paid)

☐

Additional Life with AD&D requested amount \$ _____

Long Term Disability

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Employer Paid LTD

Beneficiary

This designation applies to Life/Life with AD& D Insurance available through your employer. Designations are not valid unless signed, dated, and delivered to the Human Resources department during your lifetime.

Primary Beneficiary (Full Name)	Address	Soc. Sec #	Relationship	% of Benefit

Contingent Beneficiary (Full Name)	Address	Soc. Sec #	Relationship	% of Benefit

Signature

I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance.
I understand that my deduction amount will change if my coverage or costs change.

Employee Signature Required _____

Date (M/D/Y) _____