

Insurance Benefit Enrollment Form



Return to: Human Resources Office

If you are currently enrolled in Short-Term Disability Insurance, you don't need to complete this enrollment form or sign anything.
 If enrolling for the 1st time or increasing coverage, complete this enrollment form.
 If choosing not to enroll, fill in your name, check the decline coverage box and sign this form.

Enter your information:			
Employer Name: Wausau School District	NIS Group Number: 000107		
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:			
Short-Term Disability (Weekly Benefit cannot exceed 66-2/3% of annual salary divided by 52)			
CHECK BENEFIT DESIRED			
<input type="checkbox"/> \$147.00	\$10.89	<input type="checkbox"/> \$357.00	\$26.01
<input type="checkbox"/> \$175.00	\$12.69	<input type="checkbox"/> \$420.00	\$30.27
<input type="checkbox"/> \$224.00	\$16.32	<input type="checkbox"/> \$462.00	\$33.29
<input type="checkbox"/> \$273.00	\$19.97	<input type="checkbox"/> \$504.00	\$36.31
<input type="checkbox"/> \$301.00	\$21.77	<input type="checkbox"/> I wish to decline this coverage.	
<i>Please note if Participation Requirements are not met, you are enrolling after 30 days of becoming employed, or you are increasing coverage after 30 days of becoming employed- Evidence of Insurability/Medical Questions are required, subject to approval</i>			

Employer- Provided Insurance Benefits:
<input checked="" type="checkbox"/> Long-Term Disability

Sign here (required whether electing or declining any coverage):	
<p>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.</p> <p>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.</p>	
Signature:	Date:

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

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

Mailing: PO Box 5008, Madison, WI 53705 • Phone: 1-800-356-9601

Home Office: 1241 John Q. Hammons Drive, Madison, WI 53717

Return application to:

National Insurance Services

250 South Executive Drive, Suite 300

Brookfield, WI 53005-4273

Attention: Billing Department

Evidence of Insurability

(A separate form must be completed for each person seeking coverage.)

Check appropriate box(es): <input type="checkbox"/> Life: \$ _____ <input type="checkbox"/> Life/AD&D <input type="checkbox"/> Supp. Life:\$ _____ <input type="checkbox"/> Long Term Disability <input type="checkbox"/> AD&D:\$ _____ <input type="checkbox"/> Short Term Disability <input type="checkbox"/> AD&D:\$ _____		Reason for Applying: <input type="checkbox"/> New Hire <input type="checkbox"/> Late Enrollee <input type="checkbox"/> Increase in Coverage amount <input type="checkbox"/> Reinstatement <input type="checkbox"/> Adding Dependent(s) <input type="checkbox"/> Applying for coverage over GI <input type="checkbox"/> Other:		
APPLICANT INFORMATION				
Applicant's Name: Last, First, MI		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Age:	Date of Birth: / /
Height:	Weight:	Applicant's Social Security No. - -	Already Enrolled? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Applicant's Home Address: (Street, City, State, Zip)			Applicant's Daytime Phone No. ()	
Applicant's Current Physician's Name:		Date Last Visited: / /	Reason for Visit:	
Physician's Address: (Street, City, State, Zip)			Physician's Phone No.	
Employee Member Name: (if different than Applicant)		Employee's Job Title:		
Employee's Date of Hire:	No. of Hours Employee Works Per Week:	Employee's Annual Salary: \$		
Employer Name:		Employer's Address: (Street, City, State, Zip)		

HEALTH QUESTIONS

Check Yes or No, circle all applicable "Yes" disorders or procedures and give details below.

I. Are you currently pregnant? Yes No **If "Yes", what is your expected due date:**

II. In the past 5 years have you been diagnosed or treated by a medical professional for any of the following conditions?

A. HEART		D. PAIN & DISCOMFORT	
1. Heart ailment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Arthritis, bursitis or gout?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Chest pain, angina or shortness of breath?	<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Recurrent back pain or slipped disk?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Irregular heart beat or heart murmur?	<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Disorder of the back, neck or spine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Rheumatic fever?	<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Disorder of the muscles, bones or joints?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Disease or abnormality of heart muscle, nerves or vessels?	<input type="checkbox"/> Yes <input type="checkbox"/> No	5. Temporomandibular joint (TMJ) Disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Stress test; electrocardiogram or echocardiogram?	<input type="checkbox"/> Yes <input type="checkbox"/> No	6. Recurrent abdominal pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. TUMORS/CYSTS		E. OTHER	
1. Cancer of any type?	<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Stroke, seizure disorder or epilepsy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Tumors, cysts, or polyps?	<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Migraine or persistent headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. BLOOD AND URINE		3. Nervous/mental disorder, depression or anxiety?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1. High or low blood pressure or hypertension?	<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Dizziness or paralysis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Venereal disease, syphilis, gonorrhea, genital warts or genital herpes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	5. Asthma, emphysema, breathing or lung disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Disorder of kidneys or bladder or kidney stones?	<input type="checkbox"/> Yes <input type="checkbox"/> No	6. Indigestion, ulcers or irritable bowel?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Diabetes, high or low blood sugar?	<input type="checkbox"/> Yes <input type="checkbox"/> No	7. Chronic fatigue?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Protein, blood or sugar in urine?	<input type="checkbox"/> Yes <input type="checkbox"/> No	8. Acquired Immune Deficiency Syndrome (AIDS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Night sweats, persistent swollen glands or diarrhea?	<input type="checkbox"/> Yes <input type="checkbox"/> No	9. Aids Related Complex (ARC)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		10. Human Immunodeficiency Virus (HIV)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

HEALTH QUESTIONS *continued...*

Check all applicable disorders and give details below.

III. In the past 5 years have you been diagnosed or treated by a medical professional for a disease or disorder of the:

A. Brain or nervous system?	<input type="checkbox"/> Yes <input type="checkbox"/> No	D. Prostate, ovaries or uterus?	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Eyes, ears, nose or throat?	<input type="checkbox"/> Yes <input type="checkbox"/> No	E. Stomach, intestine, gallbladder or liver?	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. Skin or lymph nodes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	F. Thyroid, spleen or any gland?	<input type="checkbox"/> Yes <input type="checkbox"/> No

IV. In the past 5 years, have you:

A. Sought or received advice for the use of alcohol or other chemicals or drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	C. Been treated or evaluated in a hospital or medical or psychiatric facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Scheduled or undergone any surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	D. Sustained illness requiring medical care or hospitalization?	<input type="checkbox"/> Yes <input type="checkbox"/> No

V. In the last 12 months, have you used tobacco of any kind? Yes No

VI. Please list all prescribed and non-prescribed medications you currently take:

If you answered "Yes" to any Health Questions in this form, please explain below. (Please use another sheet of paper if necessary.)

Dates	Conditions	Doctor Names and Addresses	Results

ACKNOWLEDGEMENTS, AUTHORIZATIONS & SIGNATURE

I understand all statements and answers I have given are to be relied upon and form the basis of any coverage issued to me and/or my dependents under the Group Policy. I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify Madison National Life Insurance Company, Inc. of any change in my medical condition while my enrollment is pending. I agree that if my enrollment is approved by Madison National Life Insurance Company, Inc., the effective date of any coverage will be determined in accordance with the terms of the Group Policy, including any Actively at Work requirement.

I acknowledge this Evidence of Insurability form (when approved), the Group Policy, Certificate of Insurance, and any endorsement, amendment or rider hereto, are part of the insurance coverage(s) applied for. I understand that no insurance agent or broker, or persons other than officers of Madison National Life Insurance Company, Inc., can modify, waive or change this form, nor bind coverage or guarantee approval of this form.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, Veterans Administration Facility, or other medically related facility, state or local government agency, insurance or reinsurance company, consumer reporting agency, or employer, to give to Madison National Life Insurance Company, Inc., its legal representative or its reinsurers any and all such information to use for underwriting insurance. I agree that this authorization, in connection with this form, shall be valid for 24 months from my signature date and that I have the right to revoke this authorization at any time. I agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me upon request.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines, confinement in prison, and/or denial of insurance benefits.

Applicant's Signature	Date
Parent/Guardian Signature (for Dependent enrollees under age 18)	Date

FOR INSURER USE ONLY:	Decision: <input type="checkbox"/> Approved <input type="checkbox"/> Postponed <input type="checkbox"/> Declined	Effective Date:
Underwriter's Signature:		Date:

Helpful Hints When Filling Out Your "Evidence of Insurability" Application

In order to process your request for Life and or Disability Insurance you are required to complete the following application. Please use **blue or black ink** and make sure all questions are answered completely and fully. An incomplete document with missed answers will result in the application being returned to you and a delay in the processing of your request. **If you are requesting coverage for family members, complete an additional form for each person.**

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
 Mailing: PO Box 5008, Madison, WI 53705 • Phone: 1-800-356-9601
 Home Office: 1241 John Q. Hammons Drive, Madison, WI 53717

Evidence of Insurability

(A separate form must be completed for each person seeking coverage.)

Check appropriate box(es): Life: S Disease-Free Applying: New Hire Late Enrollee
 Life/AD&D Supp. L Coverage amount Reinstatement
 Long Term Disability AD&D Dependent(s) Applying for coverage over 60
 Short Term Disability AD&D

Applicant's Name: Last, First, MI _____ Age: _____ Date of Birth: _____
 Height: _____ Weight: _____ Applicant's Social Security No. _____ Already Enrolled? Yes No
 Applicant's Home Address: (Street, City, State, Zip) _____ Applicant's Daytime Phone No. _____
 Applicant's Current Physician's Name: _____ Date Last Visited: _____ Reason for Visit: _____
 Physician's Address: (Street, City, State, Zip) _____ Physician's Phone No. _____
 Employee Member Name: (if different than Applicant) _____ Employee's Job Title: _____
 Employee's Date of Hire: _____ No. of Hours Employee Works Per Week: _____ Employee's Annual Salary: \$ _____
 Employer Name: _____ Employer's Address: (Street, City, State, Zip) _____

Write your height in feet and inches

Provide both your address and your physician's address completely, including address, city, state and zip code.

Please answer each and every health question. Avoid drawing a continuous line through the yes or no boxes. Also, please make sure your check mark clearly falls within a yes or no box.

HEALTH QUESTIONS continued....
 Check all applicable disorders and give details below.

III. In the past 5 years have you been diagnosed or treated by a medical professional for a disease or disorder?
 A. Brain or nervous system? Yes No D. Prostate, ovaries or uterus? Yes No
 B. Eyes, ears, nose or throat? Yes No E. Stomach, intestine, gallbladder Yes No
 C. Skin or lymph nodes? Yes No F. Thyroid, spleen or any gland? Yes No

IV. In the past 5 years, have you:
 A. Sought or received advice the use of alcohol or other chemicals or drugs? Yes No C. Been treated or evaluated in a medical or psychiatric facility Yes No
 B. Scheduled or undergone any surgery? Yes No D. Sustained illness requiring medical hospitalization? Yes No

V. In the last 12 months, have you used tobacco of any kind? Yes No
 VI. Please list all prescribed and non-prescribed medications you currently take:

Please be sure to give the actual name of the medication you are taking, not just what the drug is used for.
 Take care to spell the medication correctly.

If you answered "Yes" to any Health Questions in this form, please explain below. (Please use another sheet of paper if necessary.)

Dates	Conditions	Doctor Names and Addresses	Results

If you answered YES to any of the Health Questions, complete this explanation section. The date should be the date of the original diagnosis.

AUTHORIZATIONS & SIGNATURE

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, Veterans Administration Facility, or other medically related agency, state or local government agency, insurance or reinsurance company, Medical Information Bureau, Inc., consumer reporting agency, or employer, to give to Madison National Life Insurance Company, Inc., its legal representative or its reinsurers any and all such information to use for underwriting insurance. I agree that this authorization, in connection with this form, shall be valid for 24 months from my signature date and that I have the right to revoke this authorization at any time. I agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me upon request. I have read the separate notice enclosed with this form pertaining to the Medical Information Bureau as required by the Fair Credit Reporting Act.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines, confinement in prison, and/or denial of insurance benefits.

Applicant's Signature _____
 Parent/Guardian Signature (for Dependent enrollees under age 18) _____

FOR INSURER USE ONLY: Decision: Approved Postponed

Read all acknowledgements and authorizations statements. Sign and date the application. Please remember – each individual should sign his or her application, however the employee needs to sign on behalf of a minor dependent child.

Please be sure to contact National Insurance Services with any changes in your health while your enrollment is pending. Failure to do so could result in the rescission of insurance and/or denial of payment of a claim.

If you have any questions when you complete this form please feel free to contact Medical Underwriting at National Insurance Services at 800-627-3660 between the hours of 8 am and 5 pm central time, Monday through Friday.