

Insurance Benefit Enrollment Form

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



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: 262.814.1397

Enter your information:

Employer Name: Princeton ISD 477		NIS Group Number: 001170	
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:	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:	
<input checked="" type="checkbox"/> Basic Life and AD&D <input checked="" type="checkbox"/> Long-Term Disability	
Optional Insurance Benefits:	
<input type="checkbox"/> Elect <input type="checkbox"/> Decline	Supplemental Life - _____ \$10,000 increments to a maximum of \$200,000 not to exceed a combined Basic and Supplemental Life amount of 7 times Annual Salary. <i>*Evidence of Insurability is required on late enrollees, increases and elections greater than \$50,000.</i>

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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More on other side ----->

Full Name:	Employer Name: Princeton ISD 477	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
Secondary Beneficiary(ies) Attach additional pages if necessary.		
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:
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Rate Table:

<u>Age</u>	<u>Employee Rate per \$1,000</u>
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	\$0.39
60-64	\$0.52
65-69	\$0.95
70-74	\$1.50
75 and over	\$2.06

To calculate your premium:

_____ / \$1,000 = _____ x _____ = \$ _____
 Coverage Amount Rate (See chart) Monthly Premium