

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

300 North Corporate Drive, Suite 300, Brookfield, WI 53045

Phone: 1.800.627.3660 Fax: 262.814.1397



Enter your information:

Employer Name: Ventura Unified School District		NIS Group Number: 040729	
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:

Optional Insurance Benefits:	
☐ Elect	☐ Decline
Basic Accidental Death and Dismemberment: Benefit Amount: <u>\$2,000</u>	
☐ Elect	☐ Decline
Voluntary AD&D (choose one)	
☐ Employee Only	
Employee Voluntary AD&D Benefit Amount Options (choose one):	
☐ Employee & Spouse	☐ \$10,000 ☐ \$100,000
☐ Employee & Child(ren)	☐ \$25,000 ☐ \$250,000
☐ Employee and Family	☐ \$50,000 ☐ \$500,000
**Please consult your FAQ sheet for Dependent Voluntary AD&D Benefit Amounts and premium amounts.	

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 next page ----->

Full Name:	Employer Name: Ventura Unified School District	Date:
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Enter your Insurance beneficiary information:

Primary Beneficiary(ies) Attach additional pages if necessary.

Full Name:	Relationship to you:	Address & Phone:	% of Benefit:
Full Name:	Relationship to you:	Address & Phone:	% of Benefit:
Full Name:	Relationship to you:	Address & Phone:	% of Benefit:

Secondary Beneficiary(ies) Attach additional pages if necessary.

Full Name:	Relationship to you:	Address & Phone:	% of Benefit:
Full Name:	Relationship to you:	Address & Phone:	% of Benefit:
Full Name:	Relationship to you:	Address & Phone:	% of Benefit:

Spouse's Signature *(May be required if choosing a primary beneficiary other than your spouse if residing in a community property state. 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. Community property states include, but might not be limited to: AZ, CA, ID, LA, NM, NV, TX, WA, and WI.)*

Spouse's Name:	Signature:	Date:
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Add spouse/dependent information:

Please provide the following information if electing Dependent Coverage. Attach additional pages if necessary.

Full Name	Date of Birth	Social Security #	Full-Time Student?
Spouse:	Date of Marriage:		n/a
Child:			☐ Yes ☐ No
Child:			☐ Yes ☐ No
Child:			☐ Yes ☐ No
Child:			☐ Yes ☐ No
Child:			☐ Yes ☐ No

Sign here:

Signature:	Date:
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