



Voluntary Life Insurance

What Is Voluntary Life Insurance?

Voluntary life insurance allows you to choose life insurance coverage at group rates. The premium payment for this coverage is paid through convenient deductions from your paycheck.

Your voluntary life insurance plan may include an option to choose dependent life insurance for your spouse and/or children, and is usually very affordable. If something unexpected happens, this plan can help cover funeral, or end of life expenses; the last thing you want to worry about during a difficult time.

What Age Should You Think About Buying Life Insurance?

Most people know that those with a family and/or a mortgage need life insurance. However, many believe that unmarried young people who have no dependents or mortgage do not need life insurance. The reality is that when people die young, the surviving family may be unprepared for the shock. Life insurance coverage may ease tension during that time by helping with unexpected expenses such as funeral fees, debts, or medical bills not covered by insurance.

How Much Life Insurance Coverage Do You Need?

Everyone's financial goals and circumstances are different, so there's no rule of thumb to tell you how much coverage you need. Think about your current and future financial obligations and how much savings, spouse's earnings, and investments you already own. To estimate your personal needs, you can use an online calculator at www.lifehappens.org.

Why Life Insurance?

Single No Dependents:

- Funeral expenses
- Medical bills
- Elderly parent support
- Debts

Single with Dependents:

- Funeral expenses
- Medical bills
- Debts
- Childcare fees
- Elderly parent support
- Education costs

Couple with No Dependents:

- Funeral expenses
- Medical bills
- Elderly parent support
- Debts

Couple with Dependents:

- Funeral expenses
- Medical bills
- Debts
- Child-rearing expenses
- Elderly parent support
- Education costs

Older Couple:

- Funeral expenses
- Medical bills
- Estate taxes
- Spouse's income
- Debts
- Assets for family

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.

Provide 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

Employer: Saucon Valley School District
NIS Group #: 015309

Enter your information:

For Open Enrollment Only – May 2026

Full Name:			Social Security Number:	
Home Address (Street Address, City, State, Zip):				
Marital Status ☐ Single ☐ Married	US Citizen? ☐ Yes ☐ No*	Gender ☐ Female ☐ Male	Occupation/Title:	
Date of Birth	Date of Hire	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:

☒ Basic Life and AD&D ☒ Long-Term Disability

Optional Insurance Benefits:

☐ Elect	☐ Decline	Employee Voluntary Supplemental Life and AD&D – Benefit Amount \$ _____ Elect in increments of \$10,000; minimum \$20,000 to a maximum of \$500,000, or 5 times Basic Annual Salary (rounded to the next higher \$10,000), whichever is lesser. Guarantee Issue (GI): \$180,000 for under age 60; \$10,000 for age 60-69; \$0 for age 70 or above. Note: Current Employees can add or increase this coverage up to the GI without any Evidence of Insurability (EOI). AD&D amount will be equal to the Supplemental Life amount. Currently Enrolled Employees who are <u>not</u> making any change to election can keep their AD&D coverage amount if this is higher.
☐ Elect	☐ Decline	Dependent Spouse Voluntary Supplemental Life and AD&D* – Benefit Amount \$ _____ Elect in \$5,000 increments to a maximum of \$250,000, not to exceed 50% of the Employee Supplemental Life. Note: New elections or increases on this coverage regardless of amount <u>will need EOI</u> .
☐ Elect	☐ Decline	Dependent Child Voluntary Supplemental Life* (for Child/ren from live birth to age 19 or age 25 if a full-time student) ☐ Option 1 - \$1,000 ☐ Option 2 - \$5,000 ☐ Option 3 - \$10,000 Note: Current Employees can add or increase this coverage up to the GI without any EOI.

*Employee Voluntary Supplemental Life has to be elected to be able to elect coverage for Dependents.

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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Enter your Life Insurance beneficiary information:

Primary Beneficiary(ies) Attach additional pages if necessary.

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

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:	Spouse's 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 #	Additional Information
Spouse:			Date of Marriage
Child:			Full Time Student? ☐ Yes ☐ No
Child:			Full Time Student? ☐ Yes ☐ No
Child:			Full Time Student? ☐ Yes ☐ No
Child:			Full Time Student? ☐ Yes ☐ No

Sign here:

Print Full Name:	
Signature:	Date:

Rate Table:

	Employee Supplemental Life	Employee Supplemental AD&D
Employee's Age	Premium Rate Per \$1,000 of Coverage	
0-19	\$0.030	\$0.026
20-24	\$0.060	\$0.026
25-29	\$0.065	\$0.026
30-34	\$0.090	\$0.026
35-39	\$0.120	\$0.026
40-44	\$0.185	\$0.026
45-49	\$0.263	\$0.026
50-54	\$0.494	\$0.026
55-59	\$0.941	\$0.026
60-64	\$1.371	\$0.026
65-69	\$2.334	\$0.026
70-74	\$4.173	\$0.026
75-99	\$15.372	\$0.026

	Dependent Spouse Supplemental Life	Dependent Spouse Supplemental AD&D
Employee's Age*	Premium Rate Per \$1,000 of Coverage	
0-19	\$0.060	\$0.026
20-24	\$0.073	\$0.026
25-29	\$0.090	\$0.026
30-34	\$0.120	\$0.026
35-39	\$0.155	\$0.026
40-44	\$0.219	\$0.026
45-49	\$0.344	\$0.026
50-54	\$0.627	\$0.026
55-59	\$1.173	\$0.026
60-64	\$1.753	\$0.026
65-69	\$2.866	\$0.026
70-74	\$5.325	\$0.026
75-99	\$17.813	\$0.026

**Dependent Spouse Rates are based on Employee's Age.*

Dependent Child Supplemental Life Rate: \$0.211 per \$1,000 of Coverage

To calculate your Life or AD&D premium(s):

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

Sample Payroll Deductions for Voluntary Life & AD&D

Based on 24 pay periods

Employee

Age	Rate	\$10,000	\$50,000	\$100,000	\$180,000
under 20	0.056	\$0.28	\$1.40	\$2.80	\$5.04
20 - 24	0.086	\$0.43	\$2.15	\$4.30	\$7.74
25 - 29	0.091	\$0.46	\$2.28	\$4.55	\$8.19
30 - 34	0.116	\$0.58	\$2.90	\$5.80	\$10.44
35 - 39	0.146	\$0.73	\$3.65	\$7.30	\$13.14
40 - 44	0.211	\$1.06	\$5.28	\$10.55	\$18.99
45 - 49	0.289	\$1.45	\$7.23	\$14.45	\$26.01
50 - 54	0.52	\$2.60	\$13.00	\$26.00	\$46.80
55 - 59	0.967	\$4.84	\$24.18	\$48.35	\$87.03
60 - 64	1.397	\$6.99	\$34.93	\$69.85	\$125.73
65 - 69	2.36	\$11.80	\$59.00	\$118.00	\$212.40
70 - 74	4.20	\$21.00	\$104.98	\$209.95	\$377.91
75 +	15.398	\$76.99	\$384.95	\$769.90	\$1,385.82

*** AD&D coverage is included in the above premiums***

Highlighted above is the guarantee issue amount, when minimum participation is met.

Spouse (rate based on employee's age)

Age	Rate	\$10,000	\$15,000	\$25,000	\$50,000
under 20	0.086	\$0.43	\$0.65	\$1.08	\$2.15
20 - 24	0.099	\$0.50	\$0.74	\$1.24	\$2.48
25 - 29	0.116	\$0.58	\$0.87	\$1.45	\$2.90
30 - 34	0.146	\$0.73	\$1.10	\$1.83	\$3.65
35 - 39	0.181	\$0.91	\$1.36	\$2.26	\$4.53
40 - 44	0.245	\$1.23	\$1.84	\$3.06	\$6.13
45 - 49	0.37	\$1.85	\$2.78	\$4.63	\$9.25
50 - 54	0.653	\$3.27	\$4.90	\$8.16	\$16.33
55 - 59	1.199	\$6.00	\$8.99	\$14.99	\$29.98
60 - 64	1.779	\$8.90	\$13.34	\$22.24	\$44.48
65 - 69	2.892	\$14.46	\$21.69	\$36.15	\$72.30
70 - 74	5.351	\$26.76	\$40.13	\$66.89	\$133.78
75 +	17.84	\$89.20	\$133.79	\$222.99	\$445.98

AD&D coverage included for spouse

Highlighted above is the guarantee issue amount, when minimum participation is met.

Dependent Child(ren)

Amount	Rate	Per Pay
\$1,000	\$0.211	\$0.11
\$5,000	\$0.211	\$0.53
\$10,000	\$0.211	\$1.06

***Monthly Premium covers ALL children to age 19; to age 25 if FT student

Highlighted above is the guarantee issue amount, when minimum participation is met.

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****300 North Corporate Drive, Suite 300****Brookfield, WI 53045****Attention: Billing Department**

Evidence of Insurability

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

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

- | | |
|---|--|
| 1. Heart ailment? | ☐ Yes ☐ No |
| 2. Chest pain, angina or shortness of breath? | ☐ Yes ☐ No |
| 3. Irregular heart beat or heart murmur? | ☐ Yes ☐ No |
| 4. Rheumatic fever? | ☐ Yes ☐ No |
| 5. Disease or abnormality of heart muscle, nerves or vessels? | ☐ Yes ☐ No |
| 6. Stress test; electrocardiogram or echocardiogram? | ☐ Yes ☐ No |

B. TUMORS/CYSTS

- | | |
|------------------------------|--|
| 1. Cancer of any type? | ☐ Yes ☐ No |
| 2. Tumors, cysts, or polyps? | ☐ Yes ☐ No |

C. BLOOD AND URINE

- | | |
|--|--|
| 1. High or low blood pressure or hypertension? | ☐ Yes ☐ No |
| 2. Venereal disease, syphilis, gonorrhea, genital warts or genital herpes? | ☐ Yes ☐ No |
| 3. Disorder of kidneys or bladder or kidney stones? | ☐ Yes ☐ No |
| 4. Diabetes, high or low blood sugar? | ☐ Yes ☐ No |
| 5. Protein, blood or sugar in urine? | ☐ Yes ☐ No |
| 6. Night sweats, persistent swollen glands or diarrhea? | ☐ Yes ☐ No |

D. PAIN & DISCOMFORT

- | | |
|--|--|
| 1. Arthritis, bursitis or gout? | ☐ Yes ☐ No |
| 2. Recurrent back pain or slipped disk? | ☐ Yes ☐ No |
| 3. Disorder of the back, neck or spine? | ☐ Yes ☐ No |
| 4. Disorder of the muscles, bones or joints? | ☐ Yes ☐ No |
| 5. Temporomandibular joint (TMJ) Disorder? | ☐ Yes ☐ No |
| 6. Recurrent abdominal pain? | ☐ Yes ☐ No |

E. OTHER

- | | |
|--|--|
| 1. Stroke, seizure disorder or epilepsy? | ☐ Yes ☐ No |
| 2. Migraine or persistent headaches? | ☐ Yes ☐ No |
| 3. Nervous/mental disorder, depression or anxiety? | ☐ Yes ☐ No |
| 4. Dizziness or paralysis? | ☐ Yes ☐ No |
| 5. Asthma, emphysema, breathing or lung disorder? | ☐ Yes ☐ No |
| 6. Indigestion, ulcers or irritable bowel? | ☐ Yes ☐ No |
| 7. Chronic fatigue? | ☐ Yes ☐ No |
| 8. Acquired Immune Deficiency Syndrome (AIDS)? | ☐ Yes ☐ No |
| 9. Aids Related Complex (ARC)? | ☐ Yes ☐ No |
| 10. Human Immunodeficiency Virus (HIV)? | ☐ Yes ☐ 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?	☐ Yes ☐ No	D. Prostate, ovaries or uterus?	☐ Yes ☐ No
B. Eyes, ears, nose or throat?	☐ Yes ☐ No	E. Stomach, intestine, gallbladder or liver?	☐ 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 for the use of alcohol or other chemicals or drugs?	☐ Yes ☐ No	C. Been treated or evaluated in a hospital or medical or psychiatric facility?	☐ Yes ☐ No
B. Scheduled or undergone any surgery?	☐ Yes ☐ No	D. Sustained illness requiring medical care or 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:**

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: ☐ Approved ☐ Postponed ☐ Declined	Effective Date:
Underwriter's Signature:		Date:

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

Check appropriate box(es): ☐ Life: S ☐ Life: AD&D ☐ Long Term Disability ☐ Short Term Disability ☐ Life: S ☐ Supp. Life: AD&D ☐ AD&D ☐ AD&D

Applying: ☐ New Hire ☐ Late Enrollee ☐ Coverage amount ☐ Reinstatement ☐ Student(s) ☐ Applying for coverage over GI

Write your height in feet and inches

Applicant's Name: Last, First, MI		Age:		Date of Birth: / /	
Height:	Weight:	Applicant's Social Security No. ☐ M ☐ F		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)			

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

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?
B. Scheduled or undergone any surgery?	☐ Yes ☐ No	D. Sustained illness requiring medical hospitalization?

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

AUTHORIZATIONS & SIGNATURE

on and form the basis of any coverage issued to me and/or my
s or failure to report information which is material to the issuance of
ennial of payment of a claim. I agree to notify Madison National Life
my enrollment is pending. I agree that if my enrollment is approved
of any coverage will be determined in accordance with the terms of

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, 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.

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.