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: All Eligible Employees

Employer Name: **Lake Elsinore Unified School District** Empl ID #			NIS Group Number: **040634**	
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:

Employer-Provided Insurance Benefits:

☒ Basic Life & Accidental Death and Dismemberment ☒ Dependent Basic Life & Accidental Death and Dismemberment

Optional Insurance Benefits:

☐ Elect ☐ Decline	**Employee Supplemental Life:** Benefit Amount $_____ *Elect in increments of $10,000 up to a maximum of $500,000, not to exceed 5 times your Annual Salary.* Guarantee Issue: $100,000 not to exceed 2 times your Annual Salary
☐ Elect ☐ Decline	**Dependent Spouse Supplemental Life:** Benefit Amount $_____ *Elect in increments of $10,000 up to a maximum of $500,000, not to exceed 100% of your Employee Supplemental Life.* Guarantee Issue: $20,000
☐ Elect ☐ Decline	**Dependent Child Supplemental Life:** For Infant(s) and Child(ren) under the age of 26. Monthly Premium is per dependent unit. ☐ $2,500 ☐ $5,000 ☐ $10,000 [Guarantee Issue]
☐ Elect ☐ Decline	**Basic Accidental Death and Dismemberment:** Benefit Amount: $2,000 **-NO COST(INCLUDED WITH BASIC AD&D)**
☐ Elect ☐ Decline	**Voluntary AD&D** (choose one) ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Employee and Family Employee Voluntary AD&D Benefit Amount Options *(choose one):* ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ $100,000 ☐ $250,000 ☐ $500,000 This coverage does not require Evidence of Insurability Form. **Please consult your FAQ sheet for Dependent Voluntary AD&D Benefit Amounts and premium amounts.

*Evidence of Insurability Form is required for amounts over the Guarantee Issue, late enrollees, and increases to coverage.

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: **Lake Elsinore Unified School District**	Date:

Enter your Life 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. 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:

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: