Insurance Benefit Enrollment Form

NATIONAL INSURANCE SERVICES

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: 262.785.9269

Enter your information:

Employer Name: **Foley ISD 51**			NIS Group Number: **001256**	
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-Provided to Eligible Employees:

☐ Eligible ☐ Not Eligible - Basic Life and AD&D

☐ Eligible ☐ Not Eligible - Long-Term Disability

Optional Insurance Benefits:

☐ Elect	☐ Decline	Dependent Life = $5,000 for Spouse and $1,000 for Children *If elected, total Monthly premium of **$0.75** covers all eligible 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:

More on other side ----------→

Full Name:	Employer Name: **Foley ISD 51**	Date:

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
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
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:

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: