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: 262.785.9269

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:		U.S. Citizen?	Date of Birth:					
ccupation/Title: Date Benefit Eligible:		Eligible:	Hours worked per week: Annual Salary:		: 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.								
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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:	D	Date:						

More on other side -----→

Full Name: Relationship to you: % of Bend Secondary Beneficiary(les) Attach additional pages if necessary. Full Name: Relationship to you: % of Bend Spouse's Signature (May be required if choosing a primary beneficiary other than your spouse. Under state law a beneficiary other than 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 Spouse: Date of Marriage: Date of Birth Social Security # Full-Time Studer Spouse: Date of Marriage: Date of Birth Social Security # Full-Time Studer Child:	Full Name:	Employe	r Name: Foley ISD 51	Date:						
Full Name: Relationship to you: % of Bene Full Name: Relationship to you: % of Bene Full Name: Relationship to you: % of Bene Relationship to you: % of Ben	Enter your Life Insurance beneficiary information:									
Full Name: Relationship to you: % of Bend Secondary Beneficiary(les) Attach additional pages if necessary. Full Name: Relationship to you: % of Bend Spouse's Signature (May be required if choosing a primary beneficiary other than your spouse. Under state law a beneficiary other than 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 Spouse: Date of Marriage: Date of Birth Social Security # Full-Time Studen Spouse: Date of Marriage: Page of Birth Social Security # Full-Time Studen Child: Pyes No Child:	Primary Beneficiary(les) Attach additional pages if necessary.									
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Full Name: Relationship to you:	Full Name:		Relationship to you:	% of Benefit						
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Please provide the following information if electing Dependent Coverage. Attach additional pages if necessary. Full Name	Spouse's Name:	Signature:								
Spouse: Date of Marriage: n/a Child:	Please provide the following information if electing Dependent Coverage. Attach additional pages if necessary.									
Child: □Yes □No Sign here: □Yes □No		T	Date of Birth	Social Security #	Full-Time Student?					
Child:	Spouse:	Date of Marriage:			n/a					
Child: Child: Child: Child: Child: Child: Child: Sign here:	Child:				□Yes □No					
Child:	Child:			7	□Yes □No					
Child: Yes No Sign here:	Child:				TYes No					
Sign here:	Child:			44	☐Yes ☐No					
	Child:				□Yes □No					
				<u> </u>						
Cignoture:	Sign here:									
Signature: Date:	Signature:									