Insurance Benefit Enrollment Form

Return 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

NATIONAL INSURANCE SERVICES

Enter your information:

Employer Name: **Educational Service Unit 13**			NIS Group Number: **036913**	
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:			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:

☒ Employee Basic Life and AD&D Amount $_____
☒ Long-Term Disability

Optional Insurance Benefits (See Rate Table on last page):

☐ Elect	☐ Decline	Employee Supplemental Life and AD&D Amount $_____ $10,000 increments to a maximum of $200,000, not to exceed 5 times annual salary, or 7 times Basic and Supplemental Life combined. *Evidence of Insurability is required for amounts over $100,000 if age 59 and under, $20,000 if age 60-69, $0 if age 70 or older, late enrollees or for increases in amounts.*
☐ Elect	☐ Decline	Spouse Supplemental Life Amount $_____ Spouse Date of Birth_____ $5,000 increments to a maximum of $100,000 not to exceed 50% of the employee's Supplemental Life amounts, whichever is less *Evidence of Insurability is required for amounts over $25,000 if age 59 and under, $10,000 if age 60-69, late enrollees or for increases in amounts.*
☐ Elect	☐ Decline	Child Supplemental Life Amount $_____ $1,000 increments to a maximum of $15,000 for ages 6 months to age 26 (infants 14 days to 6 month – 10% of elected amount) *No medical questions are required.*

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:

Instructions for the employee: Complete and return this form to your Benefits Administrator.

Instructions for the Benefits Administrator: Retain a copy of this form for your records and provide employee with a copy. Mail original to National Insurance Services at the address above.

More on other side ----------→

Full Name:	Employer Name: **Educational Service Unit 13**	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:			n/a
Child:			☐ Yes ☐ No
Child:			☐ Yes ☐ No
Child:			☐ Yes ☐ No
Child:			☐ Yes ☐ No
Child:			☐ Yes ☐ No

Sign here:

Signature:	Date:

Full Name:	Employer Name: **Educational Service Unit 13**	Date:

Rate Table and Monthly Cost:

Dependent Child Supplemental Life cost: $0.15 per $1,000 of coverage (includes all children)

AD&D cost: $0.02 per $1,000 of coverage

Employee and Spouse Supplemental Life

Rates Based on Age of Employee (as of September 1)	Rate per $1,000 of coverage
To 29	$0.04
30-34	$0.05
35-39	$0.07
40-44	$0.09
45-49	$0.15
50-54	$0.23
55-59	$0.39
60-64	$0.52
65-69	$0.95
70-74	$1.50
75+	$2.06

To calculate your monthly cost:

_____ / $1,000 = _____ x _____ = $_____

Coverage Amount Rate (See chart) Total Monthly Cost