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

Enter your information:

Employer Name: Educational Service Unit #6			NIS Group Number: 017368	
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:

☒ Long Term Disability Insurance

Voluntary Life Insurance Benefits (See Rate Table provided):

☐ Elect	☐ Decline	Employee Life Insurance *(amounts reduce beginning at age 65)* $_____ Increments of $5,000 up to a maximum of $100,000* **If you are under the age of 70 and electing more than $50,000, Evidence of Insurability is required. If you are 70 years of age or older, Evidence of Insurability is required if electing $10,000 or more.*
☐ Elect	☐ Decline	Spouse Life Insurance $_____ Increments of $2,500 up to a maximum of $50,000, but not to exceed 50% of the Employee Life Insurance amount† *†If your Spouse is under the age of 65, Evidence of Insurability is required if electing more than $25,000. If your Spouse is 65 years of age or older, Evidence of Insurability is required if electing $10,000 or more.*
☐ Elect	☐ Decline	Child Supplemental Life Insurance – ☐ $5,000 ☐ $10,000

Evidence of Insurability is needed for all late enrollees and increases in coverage.

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Full Name:	Employer Name: Educational Service Unit #6	Date:

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, make a copy for your records and return the original form to your Benefits Administrator.
Instructions for the Benefits Administrator: Retain a copy of this form for your records. Send original to National Insurance Services.

Rate Table – Employee and Spouse:

Age of Employee (as of July 1)	Rate per $1,000
0 – 29	$0.04
30 – 34	$0.06
35 – 39	$0.10
40 – 44	$0.16
45 – 49	$0.24
50 – 54	$0.38
55 – 59	$0.58
60 – 64	$0.92
65 – 69	$1.60
70 – 74	$2.40
75 – 79	$2.90
80+	$4.80
Dependent Child(ren)	$0.20

To Calculate your Premium:

1.	Write the amount of Employee Life coverage you elected.	Line 1:	_____
2.	Take the number in Line 1; divide by 1,000.	Line 2:	_____
3.	Select your rate from the table and enter on Line 3.	Line 3:	_____
4.	Multiply the numbers on Line 2 and Line 3. This represents your **monthly cost**.	Line 4:	_____
5.	Multiply the number on Line 4 by 12. This represents your **annual cost**.	Line 5:	_____
6.	Write the number of pay periods in one year.	Line 6:	_____
7.	Divide the number on Line 5 by the number on Line 6. This represents your **payroll deduction** amount.	Line :	_____

Repeat Steps above for Spouse and Child(ren) coverage elected. Note that Spouse rates are based upon the Employee's age, not the Spouse's age.

More on the next page→ (page 2 of 3)

Full Name:	Employer Name: Educational Service Unit #6	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

Total % of Benefit must equal 100%

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

Total % of Benefit must equal 100%

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 Number	Full Time Student?
Spouse:			
Child:			☐ Yes ☐ No
Child:			☐ Yes ☐ No
Child:			☐ Yes ☐ No

Sign here:

Signature:	Date: