

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

Keenan[®]

NIS
National Insurance Services

Enter your information:				Full Time Employees	
Employer Name: Petaluma City School District			NIS Group Number: 04680		
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 and AD&D		
Optional Insurance Benefits:		
☐ Elect ☐ Decline	☐ Decline	Employee Supplemental Life: Benefit Amount \$ _____ <i>Elect in increments of \$10,000 up to a maximum of \$500,000, not to exceed 5 times your Annual Salary.</i> Guarantee Issue: \$100,000 not to exceed 2 times your Annual Salary
☐ Elect ☐ Decline	☐ Decline	Dependent Spouse Supplemental Life: Benefit Amount \$ _____ <i>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</i>
☐ Elect ☐ Decline	☐ Decline	Dependent Child Supplemental Life: For Infant(s) and Child(ren) under the age of 26. ☐ \$2,500 ☐ \$5,000 ☐ \$10,000 [Guarantee Issue]

*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: Petaluma City 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:
------------	-------