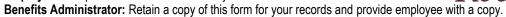
Insurance Benefit Enrollment Form

Employee: Complete and return this form to your Benefits Administrator.



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



Enter y	our infor	mation:	lembers of the Board of Education								
Employer Name: Petaluma City School District						NIS Group Number: 04680					
Full Name (Last name, First name, Middle Initial):					Date of Hire:						
Home Add	dress:			City:	State:		Zip:				
Social Security Number:			☐ Single ☐ Married	U.S. Citizen? ☐ Yes ☐ No*	Date of Birth: ☐ Male ☐ Female						
Occupation/Title:			Date Benefit	ate Benefit Eligible:		ked per weel	x: Annual Salary:				
*If you are n	ot a U.S. Citiz	en, please provide a copy of your Vis	sa.								
Insurance benefits:											
		surance Benefits:									
Σ	K]	Basic Life and AD&D									
Optional Insurance Benefits:											
□ Elect	☐ Decline	Employee Supplemental Life: Benefit Amount \$ Elect in increments of \$10,000 up to a maximum of \$500,000. Guarantee Issue: \$100,000									
□ Elect	☐ Decline	Dependent Spouse Supplemental Life: Benefit Amount \$ 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									
□ Elect	☐ 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 bee coverage(s be require employer t effective. Warning:	en given the op s), I understar d at my own e to make any ro Any person w	oportunity to apply for group insurance and that if my dependents or I decide to expense and the insurance company equired deductions, if any, from my so who knowingly presents false informational of insurance benefits.	ce and agree to o apply for cov must approve alary to pay m	o accept or decline verage at a later da coverage. If I have y portion of the ins	coverage(s) te, Evidence elected any urance premi	of Insurabilit coverage(s) um when my	y (medical questions) may above, I authorize my y insurance becomes				
Signature:			D	Date:							
More on next page→											

Enter your Life Insurance beneficiary information:											
Primary Beneficiary(ies) Attach additional pages if necessary.											
, , , , , , , , , , , , , , , , , , ,		ship to you:	Address & Phone:		% of Benefit:						
Full Name: Relation		ship to you:	Address & Phone:		% of Benefit:						
Full Name: Relation		ship to you:	Address & Phone:		% of Benefit:						
Secondary Beneficiary(ies) Attach additional pages if necessary.											
Full Name: Relation		ship to you:	Address & Phone:		% of Benefit:						
Full Name: Relation		ship to you:	Address & Phone:		% of Benefit:						
Full Name: Relation		ship 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:									

Employer Name: Petaluma City School District

Date:

Full Name: