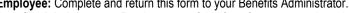
Insurance Benefit Enrollment Form

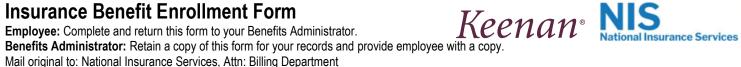




Mail original to: National Insurance Services, Attn: Billing Department

300 North Corporate Drive, Suite 300, Brookfield, WI 53045

Phone: 1.800.627.3660 Fax: 262.814.1397



More on next page ------→

Enter your information: Shared 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	t 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:							
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:	С	Pate:					

Full Name:			yer Name: Petaluma City School Dist	trict Date:					
Enter your Life Insurance beneficiary information:									
Primary Beneficiary(ies)	Attach additional pages	if necessary.							
Full Name:	Relationsh	nip to you:	Address & Phone:	% of Benefit:					
Full Name:	Relationsh	nip to you:	Address & Phone:	% of Benefit:					
Full Name:	Relationsh	nip to you:	Address & Phone:	% of Benefit:					
Secondary Beneficiary(ies) Attach additional pages if necessary.									
Full Name:	Relationsh	nip to you:	Address & Phone:	% of Benefit:					
Full Name:	Relationsh	nip to you:	Address & Phone:	% of Benefit:					
Full Name:	Relationsh	nip to you:	Address & Phone:	% of Benefit:					
			iciary other than your spouse. Under s se consult with your legal advisor befor						
Spouse's Name:		Signature:		Date:					
Sign here:									
Signature:			Date:						
			I						