Insurance Benefit Enrollment Form

NATIONAL INSURANCE SERVICES

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
250 S. Executive Drive, Suite 300, Brookfield, WI 53005-4273
Phone: 1.800.627.3660 Fax: 262.785.9269

Enter your information:

Employer Name: Ripon Area School District			NIS Group Number: 016254	
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:

☒ Long-Term Disability

Optional Insurance Benefits:

☐ Elect ☐ Decline

Short-Term Disability (Weekly Benefit cannot exceed 66-2/3% of annual salary divided by 52)

CHECK BENEFIT DESIRED

Weekly Benefit	Rate per Month
☐ $147.00	$9.79
☐ $175.00	$11.42
☐ $224.00	$14.69
☐ $273.00	$17.97
☐ $301.00	$19.60

Weekly Benefit	Rate per Month
☐ $357.00*	$23.41
☐ $420.00*	$27.24
☐ $462.00*	$29.96
☐ $504.00*	$32.68
☐ I wish to decline this coverage.	

*To be eligible for these benefit levels, you must provide proof of insurability by answering a health questionnaire and meeting medical requirements.

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: