Insurance Benefit Enrollment Form

Return to: Bonnie Detert

NIS National Insurance Services

If you are currently enrolled in Short-Term Disability Insurance, you don't need to complete this enrollment form or sign anything.
If enrolling for the first time or increasing coverage, complete this enrollment form.
If choosing not to enroll, fill in your name and social security number, check the decline box, and sign this form.

Enter your information:

Employer Name: **North Fond du Lac School District**			NIS Group Number: **016220**	
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:

☒ Long-Term Disability

☐ 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	$11.46
☐ $175.00	$13.36
☐ $224.00	$17.18
☐ $273.00	$21.02
☐ $301.00	$22.92
☐ $357.00*	$27.38

Weekly Benefit	Rate per Month
☐ $420.00*	$31.86
☐ $462.00*	$35.04
☐ $504.00*	$38.22
☐ $580.00*	$43.96
☐ $667.00*	$50.55
☐ $767.00*	$58.13

Weekly Benefit	Rate per Month
☐ $882.00*	$66.85
☐ $1,014.00*	$76.88
☐ $1,166.00*	$88.41
☐ $1,341.00*	$101.67
☐ $1,500.00*	$116.92
☐ 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:

National Insurance Services, Attn: Billing Department 250 S. Executive Drive, Suite 300 Brookfield, WI 53005-4273 Phone 1.800.627.3660