



# Employee Enrollment Form

**Return to:**  
National Insurance Services  
250 S. Executive Drive, Suite 300  
Brookfield, WI 53005-4273  
Attn: Billing Department  
1-800-627-3660

EMPLOYEE INFORMATION			
NAME OF EMPLOYER <b>SHELBYVILLE CENTRAL SCHOOLS</b>			GROUP NUMBER <b>016845</b>
NAME OF EMPLOYEE (LAST, FIRST, MIDDLE INITIAL)		SOCIAL SECURITY #	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
HOME ADDRESS OF EMPLOYEE (STREET, CITY, STATE, ZIP CODE)		U.S. CITIZEN? <input type="checkbox"/> YES <input type="checkbox"/> NO-(SEE <input checked="" type="checkbox"/> BELOW)	DATE OF BIRTH EMPLOYMENT DATE
JOB TITLE	JOB DUTIES	HOURS WORKED PER WEEK	ANNUAL SALARY

COVERAGE(S) ELECTED	
<input type="checkbox"/>	BASIC LIFE/AD&D*
<input type="checkbox"/>	DEPENDENT SPOUSE BASIC LIFE** Amount <u>\$5,000</u>
<input type="checkbox"/>	DEPENDENT CHILD BASIC LIFE** 14 days to 6 months: \$1,500 6 months to 19 or age 25 if full-time student: \$3,000
<input type="checkbox"/>	EMPLOYEE SUPPLEMENTAL LIFE* Amount \$ _____ Choice of \$10,000; \$25,000; \$50,000; \$100,000; or \$250,000
<input type="checkbox"/>	SPOUSE SUPPLEMENTAL LIFE* Amount \$ _____ 50% of the Employee Supplemental Life Insurance Amount
<input type="checkbox"/>	CHILD SUPPLEMENTAL LIFE** 14 days to 6 months: \$1,000 6 months to 19 or age 25 if full-time student: \$10,000
<input type="checkbox"/>	LONG TERM DISABILITY

\*Beneficiary designation is on the reverse side.

\*\*If your spouse and/or child(ren) are to be covered, please provide the following information. Attach additional pages if necessary.

Dependent Names	Full-Time Student?	Birth Date	Social Security No.	U.S. Citizen? If "No", see <input checked="" type="checkbox"/> below
				<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Spouse</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Child</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Child</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Child</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Child</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No

If an enrollee is not a United States citizen, please attach a copy of his or her Visa.

## EMPLOYEE COVERAGE AUTHORIZATION

**WARNING:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines, confinement in prison and/or denial of insurance benefits. This warning applies to the following states: Alabama, Alaska, Arkansas, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin, Wyoming.

**By signing this Application I understand and agree that:**

- I authorize my Employer to make any required deductions, if any, from my salary to pay the premium of my insurance coverage in effect.
- All statements and answers I have given are complete and true to the best of my knowledge and belief.
- Coverage is not in effect until final approval is given by Madison National Life Insurance Company, Inc.
- No person, except an officer of Madison National Life, is authorized to vary or modify a contract.

\_\_\_\_\_  
Employee/Applicant Signature

\_\_\_\_\_  
Date

**EMPLOYEE WAIVER OF INSURANCE**

I have been given the opportunity to apply for group insurance as presented to me, but do NOT wish to take the coverage(s). I understand that if my dependents or I decide to apply for this Group insurance plan at a later date, Evidence of Insurability will be required at my own expense, and must be approved by Madison National Life Insurance Company, Inc.

\_\_\_\_\_  
Employee/Applicant Signature

\_\_\_\_\_  
Date

**Beneficiaries:** \* (If you are married, a primary beneficiary designation of someone other than your spouse may not be effective under your state law. Please consult with your legal advisor before making such a designation.)

YOUR DEATH BENEFITS ARE TO BE PAID TO: PRIMARY BENEFICIARY(IES)			IF PRIMARY BENEFICIARY(IES) IS/ARE NOT LIVING AT THE TIME OF YOUR DEATH, BENEFITS ARE TO BE PAID TO: SECONDARY BENEFICIARY(IES)		
NAME (LAST, FIRST, MIDDLE)	RELATIONSHIP	PERCENT OF BENEFIT	NAME (LAST, FIRST, MIDDLE)	RELATIONSHIP	PERCENT OF BENEFIT

\* SPOUSE'S SIGNATURE \_\_\_\_\_ SIGNATURE DATE: \_\_\_\_\_

**Mail the original of the form to the address in top right corner of Page 1. A copy goes to the insured employee and also to the group administrator to be retained.**

FOR NATIONAL INSURANCE SERVICES USE ONLY:		
Notes:		
Date Received:	Effective Date of Coverage:	Plan No.