

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 Independent School District #2689-Pipestone Area Schools			GROUP NUMBER 001132
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)		DATE OF BIRTH	EMPLOYMENT DATE
JOB TITLE	JOB DUTIES	HOURS WORKED PER WEEK	ANNUAL SALARY

COVERAGE(S) ELECTED
<input type="checkbox"/> LONG-TERM DISABILITY

FRAUD WARNING: Any person who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines, confinement in prison, and/or denial of insurance benefits.

EMPLOYEE COVERAGE AUTHORIZATION
I hereby apply for group insurance as presented to me and authorize my employer to make any required deductions, if not 100% employer-paid , from my salary to pay the premium when my insurance becomes effective.
Dated this _____ day of _____, 20____
_____ Applicant's Signature

FOR NATIONAL INSURANCE SERVICES USE ONLY			
EFFECTIVE DATE	DATE RECEIVED	LIFE INSURANCE AMOUNT	DISABILITY AMOUNT

Waive LTD coverage: _____