



Madison
National Life

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 Macomb Intermediate School District			GROUP NUMBER 015897
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"/>	BASIC LIFE/AD&D*	Amount \$ _____ Employees applying for coverage amounts in excess of the Basic Coverage Non-Evidence Amount will be required to submit Evidence of Insurability. Evidence of Insurability must also be furnished, if, in the aggregate, benefit amount increases will exceed \$25,000.
<input type="checkbox"/>	SUPPLEMENTAL LIFE*	Amount \$ _____ Employees increasing coverage or applying for cover in excess of the Supplemental Non-Evidence Amount and late enrollees will be required to submit Evidence of Insurability.
<input type="checkbox"/>	LONG-TERM DISABILITY	
<input type="checkbox"/>	SHORT-TERM DISABILITY	

*Please complete the Beneficiary designation below.

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.

WAIVER OF INSURANCE
I have been given the opportunity to apply to Madison National Life 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 our own expense, and must be approved by Madison National Life.
Dated this _____ day of _____, 20_____
Applicant's Signature _____

EMPLOYEE COVERAGE AUTHORIZATION
I hereby apply to Madison National Life 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 _____

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

COVERAGE/BENEFICIARY CHANGES
I hereby make changes to the above coverage(s) or my beneficiary information.
Dated this _____ day of _____, 20_____
Applicant's Signature _____