Insurance Benefit Enrollment Form

Return 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

NATIONAL INSURANCE SERVICES

Enter your information:

Employer Name: Nebraska State College System				NIS Group Number: 037403	
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:		
☒ Basic Life/AD&D Amount $30,000 ☒ Long-Term Disability		
Optional Insurance Benefits (Additional Cost – See HR for details):		
☐ Elect	☐ Decline	Employee Supplemental Life/AD&D (Choose one): ☐ $10,000 ☐ $20,000 ☐ $50,000 ☐ $100,000 ☐ $180,000 Late enrollees and increases in coverage require Evidence of Insurability
☐ Elect	☐ Decline	Dependent Life (Choose one): ☐ Option 1: $2,000 Spouse, $400 Child(ren) age 14 days to 6 months, $2,000 Child(ren) age 6 months to age 26 ☐ Option 2: $10,000 Spouse, $400 Child(ren) age 14 days to 6 months, $5,000 Child(ren) age 6 months to age 26

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:

Instructions for the Employee: Complete and return this form to your Human Resource Office.

Instructions for the Human Resource Office: Retain a copy of this form for your records and provide employee with a copy upon request.

More on other side ----------→

Full Name:	Employer Name:	Date:

Enter your Life Insurance beneficiary information:

Primary Beneficiary(ies) Attach additional pages if necessary.		
Full Name:	Relationship to you:	% of Benefit
Full Name:	Relationship to you:	% of Benefit
Full Name:	Relationship to you:	% of Benefit
		Total % of Benefit must equal 100%

Secondary Beneficiary(ies) Attach additional pages if necessary.		
Full Name:	Relationship to you:	% of Benefit
Full Name:	Relationship to you:	% of Benefit
Full Name:	Relationship to you:	% of Benefit
		Total % of Benefit must equal 100%

Add spouse/dependent information:

Please provide the following information if electing Dependent Coverage. Attach additional pages if necessary.

Full Name	Date of Birth	Social Security #	Full-Time Student?
Spouse:			n/a
Child:			☐ Yes ☐ No
Child:			☐ Yes ☐ No
Child:			☐ Yes ☐ No
Child:			☐ Yes ☐ No
Child:			☐ Yes ☐ No

Sign here:

Signature:	Date: