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

Enter your information:

Employer Name: **Wallingford Swarthmore School District**			NIS Group Number: **012223**	
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:

☐ Elect ☐ Decline

Short-Term Disability

Age	Rate per $10 of Weekly Benefit	Age	Rate per $10 of Weekly Benefit
0-24	$1.40	45-49	$0.77
25-29	$1.32	50-54	$0.89
30-34	$1.19	55-59	$1.09
35-39	$0.89	60-64	$1.35
40-44	$0.71	65 +	$1.59

TO CALCULATE YOUR PREMIUM:

________ /52 = ________ x 60% = ________ x ______ /10 = ________
(Annual Salary) (Weekly Salary) (Weekly Benefit) (Rate) (Monthly Premium)

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 Benefits Administrator.

Instructions for the Benefits Administrator: Retain a copy of this form for your records and provide employee with a copy. Mail original to National Insurance Services at the address above.