

# Insurance Benefit Enrollment Form

**Employee:** Complete and return this form to your Benefits Administrator.

**Benefits Administrator:** Retain a copy of this form for your records and provide employee with a copy.

Mail original to: National Insurance Services, Attn: Billing Department

300 North Corporate Drive, Suite 300, Brookfield, WI 53045

Phone: 1.800.627.3660 Fax: 262.814.1397



<b>Enter your information:</b>			
Employer Name: <b>Rio Hondo College</b>		NIS Group Number: <b>040684</b>	
Full Name (Last name, First name, Middle Initial):		Date of Hire:	
Home Address:	City:	State:	Zip:
Social Security Number:	<input type="checkbox"/> Single <input type="checkbox"/> Married	U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No*	Date of Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female
Occupation/Title:	Date Benefit Eligible:	Hours worked per week:	Annual Salary:

\*If you are not a U.S. Citizen, please provide a copy of your Visa.

<b>Insurance benefits:</b>	
<b>Employer-Provided Insurance Benefits:</b>	
<input checked="" type="checkbox"/> <b>Basic Life and AD&amp;D</b>	
<b>Optional Insurance Benefits:</b>	
<input type="checkbox"/> Elect	<input type="checkbox"/> Decline
<b>Basic Accidental Death and Dismemberment:</b> Benefit Amount: <u>\$1,000</u>	
<input type="checkbox"/> Elect	<input type="checkbox"/> Decline
<b>Employee Supplemental Life:</b> Benefit Amount \$ _____ <i>Elect in increments of \$5,000 up to a maximum of \$525,000, not to exceed 5 times your Annual Salary.</i> Guarantee Issue: \$0 - All amounts require EOI.	
<input type="checkbox"/> Elect	<input type="checkbox"/> Decline
<b>Dependent Spouse Supplemental Life:</b> Benefit Amount \$ _____ <i>Elect in increments of \$2,500 up to a maximum of \$250,000, not to exceed 50% of your Employee Supplemental Life.</i> Guarantee Issue: \$0 - All amounts require EOI.	
<input type="checkbox"/> Elect	<input type="checkbox"/> Decline
<b>Dependent Child Supplemental Life:</b> For Infant(s) and Child(ren) under the age of 26. <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 - Not to exceed 100% of Employee Supplemental Life. Guarantee Issue: \$0 - All amounts require EOI.	
<input type="checkbox"/> Elect	<input type="checkbox"/> Decline
<b>Voluntary AD&amp;D (choose one)</b> Employee Voluntary AD&D Benefit Amount Options ( <i>choose one</i> ):	
<input type="checkbox"/> Employee Only <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$90,000 <input type="checkbox"/> \$200,000 <input type="checkbox"/> \$400,000 <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$60,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$250,000 <input type="checkbox"/> \$450,000 <input type="checkbox"/> Employee & Child(ren) <input type="checkbox"/> \$30,000 <input type="checkbox"/> \$70,000 <input type="checkbox"/> \$125,000 <input type="checkbox"/> \$300,000 <input type="checkbox"/> \$500,000 <input type="checkbox"/> Employee and Family <input type="checkbox"/> \$40,000 <input type="checkbox"/> \$80,000 <input type="checkbox"/> \$150,000 <input type="checkbox"/> \$350,000	
This coverage does not require Evidence of Insurability Form. **Please consult your FAQ sheet for Dependent Voluntary AD&D Benefit Amounts and premium amounts.	

\*Evidence of Insurability Form (EOI) is required for amounts over the Guarantee Issue, late enrollees, and increases to coverage.

<b>Sign here (required whether electing or declining any coverage):</b>	
<p>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.</p> <p><b>Warning:</b> 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.</p>	
Signature:	Date:

Full Name:	Employer Name: <b>Rio Hondo College</b>	Date:
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### Enter your Life Insurance beneficiary information:

#### Primary Beneficiary(ies) Attach additional pages if necessary.

Full Name:	Relationship to you:	Address & Phone:	% of Benefit:
Full Name:	Relationship to you:	Address & Phone:	% of Benefit:
Full Name:	Relationship to you:	Address & Phone:	% of Benefit:

#### Secondary Beneficiary(ies) Attach additional pages if necessary.

Full Name:	Relationship to you:	Address & Phone:	% of Benefit:
Full Name:	Relationship to you:	Address & Phone:	% of Benefit:
Full Name:	Relationship to you:	Address & Phone:	% of Benefit:

**Spouse's Signature** *(May be required if choosing a primary beneficiary other than your spouse if residing in a community property state. Under state law a beneficiary other than your spouse may not be honored unless your spouse signs below. Please consult with your legal advisor before making such a designation. Community property states include, but might not be limited to: AZ, CA, ID, LA, NM, NV, TX, WA, and WI.)*

Spouse's Name:	Signature:	Date:
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### 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: Date of Marriage:			n/a
Child:			<input type="checkbox"/> Yes <input type="checkbox"/> No
Child:			<input type="checkbox"/> Yes <input type="checkbox"/> No
Child:			<input type="checkbox"/> Yes <input type="checkbox"/> No
Child:			<input type="checkbox"/> Yes <input type="checkbox"/> No
Child:			<input type="checkbox"/> Yes <input type="checkbox"/> No

### Sign here:

Signature:	Date:
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