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
250 S. Executive Drive, Suite 300, Brookfield, WI 53005-4273
Phone: 1.800.627.3660 Fax: 262.814.1397

Enter your information:

Employer Name: **LANSING COMMUNITY COLLEGE**			NIS Group Number: **012284**		
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:	Date Benefit Eligible:		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 and AD&D ☒ Long-Term Disability

Optional Insurance Benefits: (See Rate Table on last page):

☐ Elect	☐ Decline	Employee Supplemental Life Insurance Amount $_______________ Employee Supplemental AD&D Insurance Amount $_______________ o $10,000 increments to a maximum of $500,000 not to exceed 5 times Annual Salary o If Participation Requirements are met, you can elect up to $150,000 without Evidence of Insurability/ Medical Questions ***Evidence of Insurability/ Medical Questions (EOI) are required for Employee Supplemental Life if Participation Requirements are not met***
☐ Elect	☐ Decline	Dependent Spouse Supplemental Life Amount $_______________ o $10,000 increments to a maximum of $20,000 not to exceed 100% of combined Basic and Supplemental Employee Life o If Participation Requirements are met, you can elect up to $20,000 without Evidence of Insurability/ Medical Questions ***Evidence of Insurability/ Medical Questions (EOI) are required if Participation Requirements are not met***
☐ Elect	☐ Decline	Dependent Basic Child(ren) Life Amount o You can choose to insure your child(ren) in the amount of $5,000 ***Evidence of Insurability/ Medical Questions (EOI) are required if you are enrolling outside of your initial 31 days of eligibility***
☐ Elect	☐ Decline	Dependent AD&D Coverage (Family Coverage- Spouse and Child/Children) o Dependent Spouse Supplemental AD&D Amount-Spouse only: 50% of Employee Supplemental AD&D amount; Spouse with Children: 40% of Employee Supplemental AD&D amount o Dependent Child(ren) AD&D Amount- Child only: 15% of Employee Supplemental AD&D amount; Child and Spouse: 10% per child of Employee Supplemental AD&D amount to a maximum of $50,000 per child

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:

More on other side -------------→

Full Name:	Employer Name: **LANSING COMMUNITY COLLEGE**	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
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

Spouse's Signature (May be required if choosing a primary beneficiary other than your spouse. 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.)

Spouse's Name:	Signature:	Date:

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:				☐ Yes ☐ No
Child:				☐ Yes ☐ No
Child:				☐ Yes ☐ No
Child:				☐ Yes ☐ No
Child:				☐ Yes ☐ No

Sign here:

Signature:	Date:

More on next page

Full Name:	Employer Name: **LANSING COMMUNITY COLLEGE**	Date:

Rate Table:

Employee Supplemental Life Insurance Rates

Age	Rate per $1,000 of Coverage
0-24	$0.037
25-29	$0.037
30-34	$0.048
35-39	$0.058
40-44	$0.074
45-49	$0.115
50-54	$0.190
55-59	$0.321
60-64	$0.493
65-69	$0.933
70-99	$1.511

AD&D Rate- Employee Supplemental AD&D Premium Rate

Rate Per $1,000 of Coverage
$0.03

Dependent Spouse Supplemental Life Insurance Rates

Age*	Rate per $1,000 of Coverage
0-29	$0.051
30-34	$0.064
35-39	$0.077
40-44	$0.098
45-49	$0.137
50-54	$0.248
55-59	$0.398
60-64	$0.701
65-69	$1.215
70-99	$1.916

*Spouse rates based on the Employee's age

Full Name:	Employer Name: **LANSING COMMUNITY COLLEGE**	Date:

Rate Table: continued

Dependent Child Supplemental Life Unit Premium Rate

Rate Per Child(ren) Unit ($5,000 in coverage)
$0.510

AD&D Rates- Dependent Spouse and Dependent Child (Family Coverage)

Rate Per $1,000 of Coverage
$0.05

Please note that the rate includes Employee, Spouse, and Child(ren) Supplemental AD&D coverage.
To calculate your Employee Supplemental Life, Employee Supplemental AD&D, Dependent Spouse Supplemental Life, Dependent Child(ren) Supplemental Life, and Dependent AD&D Insurance premiums:

________________/$1,000= ____________x______________= $_______________
Coverage Amount Rate (See Chart) Monthly Premium