



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			GROUP NUMBER
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)		U.S. CITIZEN? <input type="checkbox"/> YES <input type="checkbox"/> NO-(SEE <input checked="" type="checkbox"/> BELOW)	DATE OF BIRTH EMPLOYMENT DATE
JOB TITLE	JOB DUTIES	HOURS WORKED PER WEEK	ANNUAL SALARY

COVERAGE(S) ELECTED			
<input type="checkbox"/> BASIC LIFE*	Amount	\$ or multiple of salary	_____
<input type="checkbox"/> BASIC AD&D*	Amount	\$ or multiple of salary	_____
<input type="checkbox"/> SUPPLEMENTAL LIFE*	Amount	\$ or multiple of salary	_____
<input type="checkbox"/> SUPPLEMENTAL AD&D*	Amount	\$ or multiple of salary	_____
<input type="checkbox"/> DEPENDENT LIFE**	Option		_____
<input type="checkbox"/> LONG-TERM DISABILITY			_____
<input type="checkbox"/> LONG-TERM DISABILITY – SUPPLEMENTAL	Option		_____
<input type="checkbox"/> SHORT-TERM DISABILITY	Amount		_____

*Beneficiary designation is on the reverse side.

**If your spouse and/or child(ren) are to be covered, please provide the following information. Attach additional pages if necessary.

Dependent Names	Full-Time Student?		Birth Date	Social Security No.	U.S. Citizen? If "No", see <input checked="" type="checkbox"/> below
		Spouse			<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Child			<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Child			<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Child			<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Child			<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Child			<input type="checkbox"/> Yes <input type="checkbox"/> No

If an enrollee is not a United States citizen, please attach a copy of his or her Visa.

Form continues on Page 2.

EMPLOYEE COVERAGE AUTHORIZATION

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines, confinement in prison and/or denial of insurance benefits. This warning applies to the following states: Alabama, Alaska, Arkansas, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin, Wyoming.

By signing this Application I understand and agree that:

- I authorize my Employer to make any required deductions, if any, from my salary to pay the premium of my insurance coverage in effect.
- All statements and answers I have given are complete and true to the best of my knowledge and belief.
- Coverage is not in effect until final approval is given by Madison National Life Insurance Company, Inc.
- No person, except an officer of Madison National Life, is authorized to vary or modify a contract.

Employee/Applicant Signature

Date

EMPLOYEE WAIVER OF INSURANCE

I have been given the opportunity to apply 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 my own expense, and must be approved by Madison National Life Insurance Company, Inc.

Employee/Applicant Signature

Date

Beneficiaries: * (If you are married, a primary beneficiary designation of someone other than your spouse may not be effective under your state law. Please consult with your legal advisor before making such a designation.)

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

* SPOUSE'S SIGNATURE _____ SIGNATURE DATE: _____

Mail the original of the form to the address in top right corner of Page 1. A copy goes to the insured employee and also to the group administrator to be retained.

FOR NATIONAL INSURANCE SERVICES USE ONLY:		
Notes:		
Date Received:	Effective Date of Coverage:	Plan No.