Madison National Life

EMPLOYEE ENROLLMENT FORM

Return to:
National Insurance Services
250 So. Executive Drive
Brookfield, WI 53005
Attn: Billing Dept.
1-800-627-3660

EMPLOYEE INFORMATION

Instructions: For Employee's applying within the eligibility period. Complete all areas and please print or type.

NAME OF EMPLOYER			GROUP NUMBER	
NAME OF EMPLOYEE (Last, First, Middle Initial)		SOCIAL SECURITY NUMBER	☐ SINGLE ☐ MARRIED	☐ MALE ☐ FEMALE
HOME ADDRESS OF EMPLOYEE (Street, City, State, Zip Code)		EMPLOYEE DATE OF BIRTH	EMPLOYMENT DATE	
JOB TITLE	JOB DUTIES	HOURS WORKED PER WEEK	ANNUAL SALARY	

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*

*I understand that if I reside in a community property state, it may be unlawful to name someone other than my spouse as my beneficiary, without my spouse's consent.

The laws of some states require us to furnish you with the following notice: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of a crime of insurance fraud. In the state of Florida, any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. In the state of New Jersey, any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

COVERAGES ELECTED

I AM APPLYING FOR:

- ☐ BASIC LIFE – Amt $_____
- ☐ BASIC AD&D – Amt $_____
- ☐ OPTIONAL LIFE – Amt $_____
- ☐ OPTIONAL AD&D – Amt $_____
- ☐ DEPENDENT LIFE { ☐ Spouse ☐ Children
- ☐ SHORT-TERM DISABILITY
- ☐ LONG-TERM DISABILITY
- ☐ LTD - SUPPLEMENTAL

WAIVER OF INSURANCE

I have been given the opportunity to apply to National Insurance Services for Group Insurance as presented to me, but do NOT wish to take the coverage(s) because: _____

☐ I am not applying for any optional 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 our own expense, and must be approved by the insurance company.

Dated this _____ day of _____, 20 ____

_____
Applicant's Signature

Special notice to Pennsylvania residents: Please read and sign the back of this form.

EMPLOYEE COVERAGE AUTHORIZATION

I hereby apply to National Insurance Services for Group Insurance as presented to me and authorize my employer to make any required deductions, **if not 100% employer-paid,** from my salary to pay the premium when my insurance becomes effective.

Dated this ____ day of _____, 20 ____ _____
Applicant's Signature

FOR COMPANY USE ONLY

EFFECTIVE DATE	DATE RECEIVED	LIFE INSURANCE AMOUNT	DISABILITY AMOUNT

NOTICES FOR
PENNSYLVANIA RESIDENTS ONLY

LONG TERM DISABILITY NOTICE

If your employer elects 3/12 pre-existing exclusion for the class of employees for which you will be eligible, any Disability which begins within 12 months of your Effective Date of Insurance will not be covered if the Disability is caused or contributed to by, or results from, a Pre-Existing Condition. A "Pre-Existing Condition" means any sickness or injury for which you received medical treatment services or incurred expenses within three months immediately prior to your Individual Effective Date of Insurance. Also, the provision titled "Continuity of Coverage" described in your Certificate of coverage may apply to you.

If your employer elects the 30/5 pre-existing exclusion for the class of employees for which you will be eligible, any Disability that is caused or contributed to by, or results from, a Pre-Existing Condition will not be covered under the Policy until you have performed the material duties of your regular occupation on a full-time basis for at least five consecutive days following your Effective Date of Insurance. A "Pre-Existing Condition" means a sickness or injury for which you received medical treatment, services, or incurred expenses within 30 days immediately prior to your Individual Effective Date of Insurance. Also, the provision titled "Continuity of Coverage" described in your Certificate of coverage may apply to you.

SHORT TERM DISABILITY NOTICE

If your employer elects to have the *"Pre-Existing Exclusion in the policy, any Disability which begins within 30 days of your first Effective Date of Insurance will not be covered if the Disability is caused or contributed to by, or results from, a Pre-Existing Condition. A Pre-Existing Condition"* means any sickness or injury for which you received medical treatment services, or incurred expenses, within 30 days immediately prior to your Individual Effective Date of Insurance. Also, the section titled "Continuity of Coverage" described in your Certificate of coverage may apply to you.

FOR PENNSYLVANIA RESIDENTS ONLY

I have read and understand the notices on the front and back of this form.

_____ Date: _____ , 20 ____

Employee's Signature