



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 <b style="text-align: center;">New Hampton Community Schools			GROUP NUMBER <b style="text-align: center;">013126
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)		DATE OF BIRTH	EMPLOYMENT DATE
JOB TITLE	JOB DUTIES	HOURS WORKED PER WEEK	ANNUAL SALARY

COVERAGE(S) ELECTED	
<input type="checkbox"/> BASIC LIFE/AD&D* \$ _____	
<input type="checkbox"/> LONG-TERM DISABILITY	

*Complete the beneficiary designation below.

FRAUD WARNING: Any person who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines, confinement in prison, and/or denial of insurance benefits.

EMPLOYEE COVERAGE AUTHORIZATION	
I hereby apply to Lafayette Life 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

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

FOR NATIONAL INSURANCE SERVICES USE ONLY			
EFFECTIVE DATE	DATE RECEIVED	LIFE INSURANCE AMOUNT	DISABILITY AMOUNT