

Insurance Benefit Enrollment Form

Return to: National Insurance Services, Attn: Billing Department
 250 S. Executive Drive, Suite 300 Brookfield, WI 53005-4273
 Phone 1.800.627.3660 Fax 262.785.9269



Enter your information:

Employer Name: Oak Creek Franklin School District		NIS Group Number: 000039	
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:		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:

Short-Term Disability

Weekly Benefit*	Monthly Premium Rate
<input type="checkbox"/> \$147.00	\$11.30
<input type="checkbox"/> \$175.00	\$13.24
<input type="checkbox"/> \$224.00	\$17.08
<input type="checkbox"/> \$273.00	\$20.96
<input type="checkbox"/> \$301.00	\$22.90
<input type="checkbox"/> \$357.00**	\$27.40
<input type="checkbox"/> \$420.00**	\$31.91
<input type="checkbox"/> \$462.00**	\$35.13
<input type="checkbox"/> \$504.00**	\$38.35

*Benefit level elected cannot exceed 66-2/3% of annual salary divided by 52
 **Evidence of Insurability required regardless of effective date of coverage

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:
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Instructions for the employee: Complete and return this form to your Benefits Administrator.
Instructions for the Benefits Administrator: Retain a copy of this form for your records and provide employee with a copy. Mail original to National Insurance Services at the address above.

More on other side ----->

Full Name:	Employer Name: Oak Creek Franklin School District	Date:
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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:
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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:			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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K-C-L GROUP
BENEFITS

Kansas City Life Insurance Company
3520 Broadway, PO Box 219425
Kansas City, MO 64121-9425

Return application to: National Insurance Services
250 South Executive Drive, Suite 300
Brookfield, WI 53005-4273
Attention: Billing Department
Ph: 800-627-3660 Fx: 262-785-9269

Evidence of Insurability

(A separate form must be completed for each person seeking coverage.)

Check appropriate box(es): <input type="checkbox"/> Life: \$ _____ <input type="checkbox"/> Life/AD&D <input type="checkbox"/> Supp/Vol Life:\$ _____ <input type="checkbox"/> Long Term Disability <input type="checkbox"/> AD&D:\$ _____ <input type="checkbox"/> Short Term Disability <input type="checkbox"/> AD&D:\$ _____		Reason for Applying: <input type="checkbox"/> New Hire <input type="checkbox"/> Late Enrollee <input type="checkbox"/> Increase in Coverage amount <input type="checkbox"/> Reinstatement <input type="checkbox"/> Adding Dependent(s) <input type="checkbox"/> Applying for coverage over GI <input type="checkbox"/> Other:		
APPLICANT INFORMATION				
Applicant's Name: Last, First, MI		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Age:	Date of Birth: / /
Height:	Weight:	Applicant's Social Security No. - -	Already Enrolled? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Applicant's Home Address: (Street, City, State, Zip)			Applicant's Daytime Phone No. ()	
Applicant's Current Physician's Name:		Date Last Visited: / /	Reason for Visit:	
Physician's Address: (Street, City, State, Zip)			Physician's Phone No.	
Employee Member Name: (if different than Applicant)		Employee's Job Title:		
Employee's Date of Hire:	No. of Hours Employee Works Per Week:	Employee's Annual Salary: \$		
Employer Name:		Employer's Address: (Street, City, State, Zip)		

HEALTH QUESTIONS			
Check Yes or No, circle all applicable "Yes" disorders or procedures and give details below.			
I. Are you currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", what is your expected due date:			
II. In the past 5 years have you been diagnosed or treated by a medical professional for any of the following conditions?			
A. HEART		D. PAIN & DISCOMFORT	
1. Heart ailment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Arthritis, bursitis or gout?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Chest pain, angina or shortness of breath?	<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Recurrent back pain or slipped disk?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Irregular heart beat or heart murmur?	<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Disorder of the back, neck or spine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Rheumatic fever?	<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Disorder of the muscles, bones or joints?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Disease or abnormality of heart muscle, nerves or vessels?	<input type="checkbox"/> Yes <input type="checkbox"/> No	5. Temporomandibular joint (TMJ) Disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Stress test, electrocardiogram or echocardiogram?	<input type="checkbox"/> Yes <input type="checkbox"/> No	6. Recurrent abdominal pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. TUMORS/CYSTS		E. OTHER	
1. Cancer of any type?	<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Stroke, seizure disorder or epilepsy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Tumors, cysts, or polyps?	<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Migraine or persistent headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. BLOOD AND URINE		3. Nervous/mental disorder, depression or anxiety?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1. High or low blood pressure or hypertension?	<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Dizziness or paralysis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Venereal disease, syphilis, gonorrhea, genital warts or genital herpes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	5. Asthma, emphysema, breathing or lung disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Disorder of kidneys or bladder or kidney stones?	<input type="checkbox"/> Yes <input type="checkbox"/> No	6. Indigestion, ulcers or irritable bowel?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Diabetes, high or low blood sugar?	<input type="checkbox"/> Yes <input type="checkbox"/> No	7. Chronic fatigue?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Protein, blood or sugar in urine?	<input type="checkbox"/> Yes <input type="checkbox"/> No	8. Acquired Immune Deficiency Syndrome (AIDS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Night sweats, persistent swollen glands or diarrhea?	<input type="checkbox"/> Yes <input type="checkbox"/> No	9. Aids Related Complex (ARC)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		10. Human Immunodeficiency Virus (HIV)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

HEALTH QUESTIONS *continued*...

Check all applicable disorders and give details below.

III. In the past 5 years have you been diagnosed or treated by a medical professional for a disease or disorder of the:

A. Brain or nervous system?	<input type="checkbox"/> Yes <input type="checkbox"/> No	D. Prostate, ovaries or uterus?	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Eyes, ears, nose or throat?	<input type="checkbox"/> Yes <input type="checkbox"/> No	E. Stomach, intestine, gallbladder or liver?	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. Skin or lymph nodes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	F. Thyroid, spleen or any gland?	<input type="checkbox"/> Yes <input type="checkbox"/> No

IV. In the past 5 years, have you:

A. Sought or received advice for the use of alcohol or other chemicals or drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	C. Been treated or evaluated in a hospital or medical or psychiatric facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Scheduled or undergone any surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	D. Sustained illness requiring medical care or hospitalization?	<input type="checkbox"/> Yes <input type="checkbox"/> No

V. In the last 12 months, have you used tobacco of any kind? Yes No

VI. Please list all prescribed and non-prescribed medications you currently take:

If you answered "Yes" to any Health Questions in this form, please explain below. (Please use another sheet of paper if necessary.)

Dates	Conditions	Doctor Names and Addresses	Results

ACKNOWLEDGEMENTS, AUTHORIZATIONS & SIGNATURE

I understand all statements and answers I have given are to be relied upon and form the basis of any coverage issued to me and/or my dependents under the Group Policy. I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify Kansas City Life Insurance Company of any change in my medical condition while my enrollment is pending. I agree that if my enrollment is approved by Kansas City Life Insurance Company, the effective date of any coverage will be determined in accordance with the terms of the Group Policy, including any Actively at Work requirement.

I acknowledge this Evidence of Insurability form (when approved), the Group Policy, Certificate of Insurance, and any endorsement, amendment or rider hereto, are part of the insurance coverage(s) applied for. I understand that no insurance agent or broker, or persons other than officers of Kansas City Life Insurance Company, can modify, waive or change this form, nor bind coverage or guarantee approval of this form.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, Veterans Administration Facility, or other medically related facility, state or local government agency, insurance or reinsurance company, consumer reporting agency, or employer, to give to Kansas City Life Insurance Company, its legal representative or its reinsurers any and all such information to use for underwriting insurance. I agree that this authorization, in connection with this form, shall be valid for 24 months from my signature date and that I have the right to revoke this authorization at any time. I agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me upon request.

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.

Applicant's Signature	Date
Parent/Guardian Signature (for Dependent enrollees under age 18)	Date

FOR INSURER USE ONLY:	Decision: <input type="checkbox"/> Approved <input type="checkbox"/> Postponed <input type="checkbox"/> Declined	Effective Date:
Underwriter's Signature:		Date: