NIS
National Insurance Services

Employee Enrollment Form

Return to:
PA Municipal Authorities Association
1000 N Front Street, Suite 401
Wormleysburg, PA 17043
Attn: Kimberly A. Miller
717-737-7655

EMPLOYEE INFORMATION			
NAME OF EMPLOYER			GROUP NUMBER
NAME OF EMPLOYEE (LAST, FIRST, MIDDLE INITIAL)	SOCIAL SECURITY #	☐ SINGLE ☐ MARRIED	☐ MALE ☐ FEMALE
HOME ADDRESS OF EMPLOYEE (STREET, CITY, STATE, ZIP CODE)	**U.S. CITIZEN?** ☐ YES ☐ NO-*(SEE ☑ BELOW)*	DATE OF BIRTH	START DATE
JOB TITLE	COVERAGE EFFECTIVE DATES	HOURS WORKED PER WEEK	ANNUAL SALARY

COVERAGE(S) ELECTED

☐ BASIC LIFE* Amount $_____

☐ BASIC AD&D* Amount $_____

☐ LONG-TERM DISABILITY

☐ SHORT-TERM DISABILITY

☐ HOSPITAL INDEMINITY

*Beneficiary designation is on the reverse side.

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

EMPLOYEE COVERAGE AUTHORIZATION

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

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.**