Madison National Life

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 #	☐ SINGLE ☐ MARRIED	☐ MALE ☐ 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

☐ BASIC LIFE*	Amount	$ or multiple of salary	
☐ BASIC AD&D*	Amount	$ or multiple of salary	
☐ SUPPLEMENTAL LIFE*	Amount	$ or multiple of salary	
☐ SUPPLEMENTAL AD&D*	Amount	$ or multiple of salary	
☐ DEPENDENT LIFE**	Option		
☐ LONG-TERM DISABILITY			
☐ LONG-TERM DISABILITY – SUPPLEMENTAL	Option		
☐ 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.

Name of Spouse/Dependent	Social Security #	Date of Birth	Relationship

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.

WAIVER OF INSURANCE

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

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

EMPLOYEE COVERAGE AUTHORIZATION

I hereby apply to Madison National 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

ENR-GroupName-MO/YR

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. [STATES OF: **AZ**, **CA**, **ID**, **LA**, **NV**, **NM**, **TX**, **WA** and **WI**.]

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