



Madison
National Life

Employee Enrollment Form

Return to: Macomb ISD
Business Office
44001 Garfield Rd
Clinton Twp, MI 48038
Fx (586) 228-3562

EMPLOYEE INFORMATION			
NAME OF EMPLOYER Macomb Intermediate School District			GROUP NUMBER 015897
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

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

COVERAGE/BENEFICIARY CHANGES
I hereby make changes to the above coverage(s) or my beneficiary information.
Dated this _____ day of _____, 20_____
Applicant's Signature _____