Return to:
Macomb Intermediate School District
44001 Garfield Road
Clinton Township, MI 48038
Attn: Benefits Department

Employee Enrollment Form

EMPLOYEE INFORMATION			
NAME OF EMPLOYER Macomb Intermediate School District			GROUP NUMBER 015897
NAME OF EMPLOYEE (LAST, FIRST, MIDDLE INITIAL)	EMP ID (6 digit)	☐ SINGLE ☐ MARRIED	☐ MALE ☐ FEMALE
HOME ADDRESS OF EMPLOYEE (STREET, CITY, STATE, ZIP CODE)	U.S. CITIZEN? ☐ YES ☐ NO-(SEE ☑ BELOW)	DATE OF BIRTH	EMPLOYMENT DATE
JOB TITLE / JOB DUTIES		HOURS WORKED PER WEEK	ANNUAL SALARY

COVERAGE(S) ELECTED

☐	BASIC LIFE/AD&D* Amount $______________ Employees applying for coverage amounts in excess of the Basic Coverage Non-Evidence Amount will be required to submit Evidence of Insurability. Evidence of Insurability must also be furnished, if, in the aggregate, benefit amount increases will exceed $25,000.
☐	SUPPLEMENTAL LIFE* Amount $______________ Employees increasing coverage or applying for cover in excess of the Supplemental Non-Evidence Amount and late enrollees will be required to submit Evidence of Insurability.

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. This warning applies to the following states: Alabama, Alaska, Arkansas, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin, Wyoming.

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**

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:		