Insurance Benefit Enrollment Form

Annual Open Enrollment— Coverage Effective January 1, 2025

Return to: Sara Farrell, Benefits Coordinator

Enter your information:

Employer Name: **Kalamazoo Regional Educational Service Agency**			NIS Group Number: **026014**	
Full Name (Last name, First name, Middle Initial):			Date of Hire:	
Home Address:	City:	State:	Zip:	
Social Security Number:	☐ Single ☐ Married	U.S. Citizen? ☐ Yes ☐ No*	Date of Birth:	☐ Male ☐ Female
Occupation/Title:			Hours worked per week:	Annual Salary:

*If you are not a U.S. Citizen, please provide a copy of your Visa.

Employer Provided Insurance Benefits:

☒ Basic Life and AD&D ☒ Long Term Disability

Optional Insurance benefits: (see rate table)

☐ Elect	☐ Decline	**Employee Supplemental Life and AD&D Amount $_____** $10,000 increments up to the lesser of 5 times Annual Salary or $500,000. *Evidence of Insurability is required:* • *Employees can choose up to $20,000 of new coverage or an increase in current coverage of $20,000, not to exceed $140,000* • *If you are enrolling late, requesting an increase in coverage or requesting amount over the Guarantee Issue amount* • *Prior declines/incomplete applications*
☐ Elect	☐ Decline	**Spouse Supplemental Life and AD&D Amount $_____** Spouse — $5,000 increments to a maximum of $250,000, not to exceed 50% of Employee Supplemental Life and AD&D Amount. *Evidence of Insurability is required :* • *Any amount* • *If you are enrolling late, requesting an increase in coverage or requesting amount over the Guarantee Issue amount* • *Prior declines/incomplete applications*
☐ Elect	☐ Decline	**Child Supplemental Life and AD&D** Age 14 days to 6 months—$250 Age 6 months through Age 19 or 25 if full-time student ☐ **Option 1:** $2,500 ☐ **Option 2:** $5,000 ☐ **Option 3:** $7,500 ☐ **Option 4:** $10,000 *Evidence of Insurability is required for all coverage amounts over $5,000*
☐ Elect	☐ Decline	**Short Term Disability Amount $_____** $100 increments up to 60% of Pre-disability Earnings (rounded to the next lower $100) • Maximum Weekly Benefit of $1,200 • Minimum Weekly Benefit is 10% of Gross Short-Term Disability Benefit *Evidence of Insurability is required if you are enrolling late or prior declines* ***Please note the Pre-existing Condition Exclusion applies to any new or increased amounts elected during the Annual Open Enrollment Period***

Full Name: N/A	Employer Name: **Kalamazoo Regional Educational Service Agency**	Date: N/A

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

Total % of Benefit must equal 100%

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

Total % of Benefit must equal 100%

Add Spouse/Child information:

Please provide the following information if electing Spouse or Child Supplemental Coverage. Attach additional pages if necessary.

Full Name	**Date of Birth**	**Social Security Number**
Spouse:		
Child:		
Child:		

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:

Instructions for the employee: Complete, make a copy for your records and return the original form to **Paige Stermer.**

Instructions for the Benefits Administrator: Retain a copy of this form for your records. Send the original to National Insurance Services.