

Employee Enrollment Form

EMPLOYEE INFORMATION			
NAME OF EMPLOYER CENTER GROVE COMMUNITY SCHOOL CORPORATION			GROUP NUMBER 016588
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)		U.S. CITIZEN? <input type="checkbox"/> YES <input type="checkbox"/> NO (SEE BELOW)	DATE OF BIRTH EMPLOYMENT DATE
JOB TITLE	JOB DUTIES		HOURS WORKED PER WEEK ANNUAL SALARY

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

COVERAGE(S) ELECTED
<input type="checkbox"/> BASIC LIFE/AD&D* <input type="checkbox"/> SUPPLEMENTAL LIFE* Amount \$ _____ Increments of \$1,000, Lesser of 5 x Annual Salary or \$500,000 <input type="checkbox"/> LONG-TERM DISABILITY

EMPLOYEE COVERAGE AUTHORIZATION

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
-------------------------------------	-------------

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:
---------------------	-----------------

FOR NATIONAL INSURANCE SERVICES USE ONLY:

Notes:

Date Received:	Effective Date of Coverage:	Plan No.
-----------------------	------------------------------------	-----------------