



**IOWA SCHOOLS EMPLOYEE BENEFITS ASSOCIATION
ENROLLMENT / CHANGE FORM**

Effective Date: / /
Effective Date: / /
Effective Date: / /

New Hire
 Change in Coverage
 Termination

SECTION 1: EMPLOYER AND EMPLOYEE INFORMATION

Employer Name: _____ Client Code/Group #: _____ Division #: _____ Department: _____

Employee Name (Last, First, MI): _____ Social Security #: _____ Home Phone #: _____

Employee's Address (Street, City, State, Zip): _____

Employee's Date of Birth: _____ Hours Worked Per Week: _____ Marital Status:
 Married Single

Employee's Occupation/Class: _____ Effective Date of Coverage: _____ Annual Salary: _____

Gender: M F Retired Active

SECTION 2: CHECK TYPE OF COVERAGE (PPO 250, PPO 500, PPO 750, etc...)

Please specify Medical Plan _____
Please specify Dental Plan _____

COVERAGE TYPE	MEDICAL		VISION		DENTAL		LIFE/ADAD		LTD OPTION		VOL LIFE/ADAD AMOUNT		DEP LIFE		DEP LIFE AMOUNT	
	A	W	A	W	A	W	A	W	A	W	A	W	A	W	A	W
A = Accept W = Waive																
Employee Only																
Family																

Indicate the reason for waiving coverage: _____

SECTION 3: ELIGIBLE PARTICIPANTS (If additional dependents, attach separate sheet)

Last Name	First Name	Social Security #	Date of Birth		Sex	FT Student Over 19	Expected Graduation Date	Handicapped Dependent	Check if
			MM	DY					
Employee	SUBSCRIBER SEE ABOVE								
Spouse									
Dependent									
Dependent									
Dependent									
Dependent									

SECTION 4: MEDICARE INFORMATION

Name of Person Covered by Medicare	EFFECTIVE DATES		DISABLED?		ESRD?	
	PART A	PART B	YES	NO	YES	NO
	/ /	/ /				
	/ /	/ /				
	/ /	/ /				

SECTION 5: BENEFICIARY INFORMATION - Please note the employee is the beneficiary for dependent life or spouse or children voluntary life

Name of Beneficiary (Last Name, First, MI)	Relationship	Benefit %
Primary:		
Secondary:		

SECTION 6: REASON FOR ADDING COVERAGE

EFF. DATE OF CHANGE: / /

Open Enrollment

Birth / Adoption

Marriage

Loss of Other Grp. Coverage

Court Order (attach a copy)

Employment Status Change

Other (explain): _____

SECTION 7: REASON FOR TERMINATING COVERAGE

Effective Date of Change: / /

Date Coverage Terminates: / /

Termination of Employment

Divorce

Age Limit

Medicare

Other (explain): _____

SECTION 8: SALARY, NAME AND/OR ADDRESS CHANGES

Salary \$: _____ Eff. Date: / /

New Name: _____

Former Name: _____

New Address: _____

Important Notice

I represent that all information supplied in this application is true and complete. I have read and understand the Acceptance and/or Waiver Statements, the Existing Condition Exclusion and the Special Enrollment Rights information provided on the back of this enrollment application.

IMPORTANT: PLEASE READ AND SIGN FORM.