



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

- New Hire
- Change in Coverage
- Termination

Effective Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Effective Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Effective Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

SECTION 1: EMPLOYER AND EMPLOYEE INFORMATION									
Employer Name:				Client Code/Group #:			Division #/ Department:		
Employee Name (Last, First, MI):						Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security #:		
Employee's Address (Street, City, State, Zip):								Home Phone #:	
Employee's Date of Birth:		Employee's Date of Hire:		Hours Worked Per Week:		<input type="checkbox"/> Active <input type="checkbox"/> Retired		Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single	
Employee's Occupation/Class:			Effective Date of Coverage:			Annual Salary:			

SECTION 6: REASON FOR ADDING COVERAGE	EFF. DATE OF CHANGE
<input type="checkbox"/> Open Enrollment	
<input type="checkbox"/> Birth / Adoption	
<input type="checkbox"/> Marriage	
<input type="checkbox"/> Loss of Other Grp. Coverage	
<input type="checkbox"/> Court Order (attach a copy)	
<input type="checkbox"/> Employment Status Change	
<input type="checkbox"/> Other (explain)	

SECTION 2: CHECK TYPE OF COVERAGE																			
Please specify Medical Plan _____ (PPO 250, PPO 500, PPO 750. etc...)																			
Please specify Dental Plan _____																			
COVERAGE TYPE ▼	MEDICAL		VISION		DENTAL		LIFE/ AD&D		LIFE / AD&D OPTION ▼	LTD		LTD OPTION ▼	VOL. LIFE / AD&D		VOL. LIFE / AD&D AMOUNT ▼	DEP. LIFE		DEP. LIFE AMOUNT ▼	
A = Accept W = Waive	A	W	A	W	A	W	A	W	▼	A	W	▼	A	W	▼	A	W	▼	
Employee Only	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		
<b>REQUIRED FOR ALL WAIVERS</b>										Indicate the reason for waiving coverage ►									

SECTION 7: REASON FOR TERMINATING COVERAGE			
<input type="checkbox"/> Termination of Employment			
<input type="checkbox"/> Divorce	<input type="checkbox"/> Spouse's Group Coverage		
<input type="checkbox"/> Age Limit	<input type="checkbox"/> Individual Coverage		
<input type="checkbox"/> Medicare	<input type="checkbox"/> Deceased		
<input type="checkbox"/> Other (explain)			
Effective Date of Change		_____ / _____ / _____	

SECTION 3: ELIGIBLE PARTICIPANTS (if additional dependents, attach separate sheet)							Check if ▼			ADD	REMOVE	
Last Name	First Name	Social Security #	Date of Birth			Sex	FT Student Over 19	Expected Graduation Date	Handicapped Dependent			
Employee	<i>SUBSCRIBER SEE ABOVE</i>			MM	DY	YR	M / F					
Spouse												
Dependent												
Dependent												
Dependent												
Dependent												

SECTION 8: SALARY, NAME and/or ADDRESS CHANGES	
Salary \$	Eff. Date. _____ / _____ / _____
New Name:	
Former Name:	
New Address:	

SECTION 4: MEDICARE INFORMATION				EFFECTIVE DATES		DISABLED?		ESRD?	
Name of Person Covered by Medicare			Medicare ID Number	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 child(ren) voluntary life.		
Name of Beneficiary (Last Name, First, MI)		Relationship
Benefit %		
Primary:		
Secondary:		

**Important Notice**

**IMPORTANT: PLEASE READ AND SIGN FORM.**

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 Preexisting Condition Exclusion and the Special Enrollment Rights information provided on the back of this enrollment application.

Employee Signature: \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_