



IOWA SCHOOLS EMPLOYEE BENEFITS ASSOCIATION

ENROLLMENT / CHANGE FORM

- New Hire
- Change in Coverage

Check here if you are submitting a HIPAA Certificate of Creditable Coverage with the application.

- Termination Eff. Date / /
- COBRA Eff. Date / /

SECTION I – EMPLOYER AND EMPLOYEE INFORMATION									
Employer Name:			Client Code/Group #:			Division #:			
Employee Name (Last, First, MI):					Sex:	Social Security #:			
					? M ? F	- - -			
Employee's Address (Street, City, State, Zip):					Employee's Phone # Home:		Employee's Phone # Work:		
Employee's Date of Birth:		Employee's Date of Hire:		Hours Worked Per Week :		? Active ? Retired		Marital Status: ? Married ? Single	
Employee's Occupation:	Benefit Class:	Effective Date of Coverage:		Salary:		? Yearly ? Monthly	? Bi-Wkly ? Weekly	? Hourly	

SECTION IV: REASON FOR ADDING COVERAGE	
<input type="radio"/>	Open Enrollment
<input type="radio"/>	Birth / Adoption
<input type="radio"/>	Marriage
<input type="radio"/>	Loss of Other Grp. Coverage
<input type="radio"/>	Court Order (attach a copy)
<input type="radio"/>	Employment Status Change
<input type="radio"/>	Other (explain)
Effective Date of Change <u> </u> / <u> </u> / <u> </u>	

SECTION II: CHECK TYPE OF COVERAGE		Please specify Medical Plan _____ (PPO \$250, PPO \$500, etc...)														
COVERAGE TYPE ▼	MEDICAL + RX VISION (If Applicable)		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	W	A	W	A	W		A	W		A	W		A	W	
A = Accept W = Waive	A	W	A	W	A	W		A	W		A	W		A	W	
Employee Only	?	?	?	?	?	?		?	?		?	?		?	?	
Family	?	?	?	?	?	?		?	?		?	?		?	?	
	?	?	?	?	?	?		?	?		?	?		?	?	
	?	?	?	?	?	?		?	?		?	?		?	?	

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

SECTION III: 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	Disabled					
Employee	SUBSCRIBER SEE ABOVE			MM	DY	YR	M / F						
Spouse													
Dependent													
Dependent													
Dependent													
Dependent													

SECTION VI: SALARY CHANGE	
Salary \$	Eff. Date.

SECTION VIII - BENEFICIARY INFORMATION FOR EMPLOYEE COVERAGE		
<i>(The beneficiary for dependent life coverage or supplemental life for the spouse or children will automatically be the employee.)</i>		
Name of Beneficiary (Last Name, First, MI)	Relationship	Benefit %
Primary:		
Secondary:		

SECTION IX: OTHER GROUP COVERAGE	
Complete if you or any of your dependents have any other health insurance coverage.	
Name of Employer:	_____
Insurance Carrier:	_____
Name of Insured	_____
Identification #:	_____
Group #:	_____
Effective Date:	<u> </u> / <u> </u> / <u> </u>
Is Coverage Still in Effect?	<input type="radio"/> Yes <input type="radio"/> No

IMPORTANT: PLEASE READ AND SIGN BELOW. 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 page 2 of this enrollment application.

Employee Signature: _____ Date / /

ISEBA INTERNAL USE ONLY
 Coverage Eff Date: _____ Premium Date: _____

After this enrollment form is completed and signed, send the original to ISEBA and make two copies--one for the employer, one for the employee.

By signing the front of the enrollment form I am stating that I understand and agree with the following Acceptance and/or Waiver Statements and have read the Preexisting Condition Exclusion and Special Enrollment Rights.

Acceptance and/or Waiver Statements

- My dependents are not eligible for any coverage for which I am not covered.
- My Dependents, including stepchildren, foster children and those over the maximum age, are eligible for coverage based on policy provisions. Eligibility for my dependents over the maximum age will be verified when claims are submitted.
- If I decline coverage, I and/or my dependents must wait until the next annual open enrollment period to enroll, unless I become eligible as a result of special enrollment rights.
- If I cancel coverage for myself and/or my Dependents, and then request coverage at a later date, I and/or my Dependents will be considered a late enrollee. As a late enrollee, I and/or my Dependents may not enroll until the next annual open enrollment period and/or may be subject to the preexisting condition exclusion. However, I will not be considered a late enrollee for employee and/or Dependent coverage and will not have to wait until the next annual open enrollment period if:
 - (a) enrollment is requested under one of the special enrollment rights;
 - (b) request is made within the time period specified for that special enrollment right; and
 - (c) any required information or proof is furnished.
- If I cancel any type of life and/or disability coverage, I may apply at a later date; however, the enrollment will be subject to evidence of insurability and will be subject to underwriting approval.
- If I cancel coverage, I cannot under any circumstance enroll in the policy once I have retired.
- If the Group Policy requires that I make contributions, I authorize my employer to deduct from them from my pay.
- If I knowingly provide false or misleading information, I may be guilty of insurance fraud, which is punishable by law.

Preexisting Condition Exclusion

Preexisting Condition Exclusions apply to Late Enrollees.

A Preexisting condition is a condition present before your enrollment date in any new health plan. If you and your dependents received, or were recommended to receive medical advice, diagnosis, care, or treatment for a condition (physical or mental), in the last six months, the preexisting exclusion will apply. This preexisting exclusion period is 12 months and will exclude benefits for any treatment or services during the preexisting condition period.

Late enrollees may not enroll until the next annual open enrollment period at which time the preexisting condition exclusion period will apply. The preexisting exclusion will not apply to newborns or children under the age of 18 whom are adopted or placed for adoption if coverage is requested within 31 days of birth, adoption or placement for adoption, or pregnancy.

The preexisting exclusion period may be reduced by the number of days you and/or your dependents were covered under a prior health plan. You and/or your dependents have the right to demonstrate previous coverage by requesting a certificate of coverage from your prior health plan. Once the amount of prior creditable coverage has been determined, you will receive a notice stating the length of any preexisting condition exclusion period that applies to you and/or dependents.

Special Enrollment Rights

If you and/or your dependents decline coverage because you have other health insurance, you may enroll within 31 days following the loss of other insurance. Loss of coverage includes:

- COBRA or state continuation coverage exhausted
- Reduction in work hours or termination of employment
- Employer contributions have terminated
- Death, divorce or legal separation

If you and/or your dependents have declined coverage, you may enroll within 31 days if there is a change in your family status. This includes:

- Marriage
- Birth of child
- Adoption or placement for adoption

If you and/or your dependents do not enroll within 31 days, you will be considered a late enrollee and are subject to the Preexisting Condition Exclusion rules.

If you are already enrolled for coverage, and your dependents have declined coverage, your dependent child may enroll within 31 days, due to a court or administrative order to provide health coverage.

If you have a change in employee status, which results in a change of benefits you may enroll within 63 days.