

Effective Date

Rev. 04/2020



Employee Signature:

IOWA SCHOOLS EMPLOYEE BENEFITS ASSOCIATION ENROLLMENT / CHANGE FORM

SECTION 1: EMPLOYER AND EMPLOYEE INFORMATION											Employer Name:												R	REASON FOR ADDING DATE OF COVERAGE CHANGE								
Employee Name (Last, First, MI): Social S Employee's Home Address (Street, City, State, Zip):											al Security #:				Gender: D. □M □F		Date of Birth:				Marital Status: ☐ Married ☐ Single			ماہ		□ Open Enrollment						
																					- Walled E of				JIC		□ Birth / Adoption					
																		Home Phone				one #:					□ Marriage					
																		Hours Worked Per Ani									□ Loss of Other Group Coverage					
Date of Hire:	E	Effective Date of Coverage:							Active	Occupation Class:				Week:			orked Per Annua		nual Salary:					Court Or	der (a	ttach	a copy)					
□ Retired]	. -	□ Employment Status Change					
SECTION 2: CHECK TYPE OF COVERAGE													e specify Medical Plane e specify Dental Plan														Other (ex					
									LIFE/				LTD		OL.	VOL. LIFE/				DEP.				ent Expense /					V. 10. 10. 10. 10. 10. 10. 10. 10. 10. 10			
COVERAGE TYPE		MEDIC	AL V	VISION	N C	DENTAL		LIF AD		AD&D OPTION	LT	TD	OPTION			AD&		DEP.		LIFE AMOUN	T	Critical Illness To be covered AE Unit			CI		SECTION 7: REASON FOR TERMINATING COVERAGE					
A = Accept										7		1		930,500	3,535455					→	0.54.54.5	loyee		AE OI	Oint							JOVENAGE
W = Waive		A	N .	A	W	A	W	A	W		A	W		A	W	\leftarrow		Α	W		Only					-	┤╶├□		ion of	т <u>.</u>		
Employee Only	<i>'</i>		X	_)(\downarrow	X)			 					EE &	Spou	-				-				•	Group Coverage
Family		(X)	X	X	X	X											_(ال)	Child				***						Individual	Coverage
If applying for Critical Illness (CI) coverage this question must be answered: During any Proposed Insured used any form of tobacco or nicotine-based products or substitutes s											ring the past 12 months,has Employee: □ Yes tes such as patches or gum? Spouse: □ Yes															□ Deceased						
			14, 14, 17, 17, 17	cessors state	NAMES OF STREET	entry 2000	V9435154415				31 14 15 E	(State et al.		1015011		SCS1-18-6-2-17												Other (e:	xplain)		
SECTION			Section .		1				ition	aı deper					e sn	eet)				Date of	Di-Al-	<u> </u>	Sex			OVE E	E	ffective Da	te of	Chan	ge	1 1
Last Name (If different from employee) First Name Soc										Social	Security				MM DY			YR M/		—	ADD	REMOVE	Freez.									
Spouse		***************************************																	IVII	M D		N.		,,			N	SECTION 8: NAME and/or ADDRESS CHANGES				
Dependent																												ew Name:				
Dependent																																
Dependent					"			****			\top																	ormer Name				
Dependent																											1	ew Address	<u> </u>			
SECTION	⊥ 4: ME	DICAF	RE II	NFO	- RMA	ATIC	NC									EFFEC	CTIVE	E DA	\TES	3	DISA	BLE	0?	E	SRD?							
Name of Person Covered by Medicare Medicare ID											D Number PA				RTA			PART B		YES	YES NO		YES NO		10							
																									-		Seco	ndary C	ovei	age	:	
SECTION	- DC	NEELO	1 A D	VIN	EΛΡ		TIO	NI I	Diaa	aa nata t	ho 0.	molos	oo ie tho	hon	oficio	on for a	dener	ndar	ot life	or enoug	se or ch	ild(re	n) vo	lunta	ny life							
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Name of Beneficiary (Last Name, First, MI)															Itelaa	IOI IOI II	Υ	-				-										
Primary:																																
Secondary:																<u> </u>															AD AND SIG	N FORM. pplication is true
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Date _