IOWA SCHOOLS EMPLOYEE BENEFITS ASSOCIATION
ENROLLMENT / CHANGE FORM

☐ **New Hire** **Effective Date:** / /
☐ **Change in Coverage** **Effective Date:** / /
☐ **Termination** **Effective Date:** / /

SECTION 1: EMPLOYER AND EMPLOYEE INFORMATION

Employer Name: Camanche Comm Sch Dist #300339

Employee Name (Last, First, MI):	Social Security #:	Gender: ☐M ☐F	Date of Birth:	Marital Status: ☐ Married ☐ Single
Employee's Home Address (Street, City, State, Zip):				Home Phone #:
Date of Hire:	Effective Date of Coverage:	□ Active □ Retired	Occupation Class:	Hours Worked Per Week: / Annual Salary:

SECTION 2: CHECK TYPE OF COVERAGE

Please specify Medical Plan _____
Please specify Dental Plan ISEBA DELTA DENTAL

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	○	○	○	○	○	○	○	○		○	○		○	○		□	□	
Family	○	○	○	○	○	○										○	○	

Accident Expense / Critical Illness			
To be covered	AE	Unit	CI
Employee Only	☐		☐
EE & Spouse	☐		☐
EE & Children	☐		☐
Family	☐		☐

If applying for Critical Illness (CI) coverage this question must be answered: During the past 12 months,has any Proposed Insured used any form of tobacco or nicotine-based products or substitutes such as patches or gum? Employee: □ Yes □ No Spouse: □ Yes □ No

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

	Last Name *(if different from employee)*	First Name	Social Security #	Date of Birth MM	DY	YR	Sex M / F	ADD	REMOVE
Spouse									
Dependent									
Dependent									
Dependent									
Dependent									

SECTION 4: MEDICARE INFORMATION

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

Employee Signature: _____ Date _____

SECTION 6: REASON FOR ADDING COVERAGE

		EFF. DATE OF CHANGE
☐	Open Enrollment	
☐	Birth / Adoption	
☐	Marriage	
☐	Loss of Other Group Coverage	
☐	Court Order (attach a copy)	
☐	Employment Status Change	
☐	Other (explain)	

SECTION 7: REASON FOR TERMINATING COVERAGE

☐	Termination of Employment		
☐	Divorce	☐	Spouse's Group Coverage
☐	Age Limit	☐	Individual Coverage
☐	Medicare	☐	Deceased
☐	Other (explain)		
Effective Date of Change	/ /		

SECTION 8: NAME and/or ADDRESS CHANGES

New Name:	
Former Name	
New Address	

Secondary Coverage :

_____
_____
_____

IMPORTANT: PLEASE READ AND SIGN FORM.

I represent that all information supplied in this application is true and complete.

Rev. 04/2020