~ Post-Doctoral Associates ~
2016 Enrollment Form

Name: _____ **ISU Plan Effective Date:** _____

Address: _____ **University ID:** _____

City/ST/Zip: _____ **Date of Hire:** _____

Use this form to change your default Health and Dental plans and/or to enroll you family members in ISU Plan Benefits during your initial enrollment period.
Return completed form to: University Human Resources Service Center, 3810 Beardshear Hall, Ames, IA 50011-2033 before your assigned deadline.

Are you enrolled in another health or dental plan as a dependent? **Yes** or **No** *(circle one).* Double coverage with a State of Iowa employee's plan is not permitted. Coordination of benefits (COB) may apply to other employer's plans.

YOUR PRE-TAX OPTIONS

HEALTH & PHARMACY INSURANCE

Your Monthly Amount	**Yourself Only**	**Yourself & Spouse/Partner****	**Yourself & Child(ren)**	**Yourself & Family****	**Post Doc Pays**
Opt Out – ☐ *Check here if you do not want Health Insurance.*	***International Post Docs are not eligible to opt out.***				
HMO (Blue Advantage) & Express Scripts Rx	$0.00	$78.00	$46.00	$112.00	
PPO (Alliance Select) & Express Scripts Rx	$20.00	$263.00	$173.00	$339.00	
Your *Double Spouse/Partner Share	----------	----------	----------	----------	
HMO (Blue Advantage) & Express Scripts	N/A	N/A	N/A	$0.00	
PPO (Alliance Select) & Express Scripts	N/A	N/A	N/A	$97.00	

Double Spouse** option is available when ***both employees work for ISU and are eligible to share a contract in benefits in the ISU Plan. See ISU Benefits Consultant for option details.
** **Partners & FTS>26 – The federal tax code does not recognize a domestic partner or student >age 26 as a dependent for tax purposes. The benefit premiums may be treated as taxable and ISU will withhold taxes on its value.**

DENTAL INSURANCE

Your Monthly Amount	**Yourself Only**	**Yourself & Spouse/Partner****	**Yourself & Child(ren)**	**Yourself & Family****	**Post Doc Pays**
Opt Out – ☐ *Check here if you do not want Dental Insurance*					
Basic Delta Premier	$0.00	$30.00	$37.00	$45.00	
Comprehensive Delta Premier	$16.00	$77.00	$82.00	$96.00	
Your *Double Spouse/Partner Share	----------	----------	----------	----------	
Basic Delta Premier	N/A	N/A	N/A	$9.50	
Comprehensive Delta Premier	N/A	N/A	N/A	$35.00	

*** See Double Spouse above under Health**
** **See Partners & FTS> 26 above under Health**

HEALTH/DENTAL INSURANCE – YOU AND YOUR ELIGIBLE DEPENDENTS | **HMO MEMBERS ONLY**

	Social Security Number or indicate Foreign National (FN)	Name (Last, First, Middle Initial)	Y/N *Medicare Enrolled	Birth Date	M/F Gender	Dependent Child status when over 26 **FTS**-unmarried, full-time student **LTD**-unmarried, permanent disabled (verified by Wellmark)	Primary Care Physician (PCP) name/code	Female members may also designate Primary OB-GYN
Yourself								
Spouse/ Partner								
Child								
Child								
Child								
Child								

Disclosure of your social security number (SSN) is requested from you in order for Iowa State University (ISU) to administer benefits. The IRS requires that Wellmark report this information using the Social Security number or tax identification number of the plan member and each dependent. If Wellmark does not have Social Security or tax identification numbers, they will be unable to report and send the information needed to complete federal tax returns. Federal and State law protects the privacy and security of your SSN and ISU will not disclose your SSN without your consent for any other purposes except as allowed by law. ISU is working to minimize the use of SSN's within its business processes. ***If Medicare eligible, please provide Medicare information to ISU Benefits Office.**

AGREEMENT AND CERTIFICATION

I certify that I am legally authorized to apply for coverage for myself and all other persons named in this application. I understand that I am making application for the coverages sponsored by my employer in the ISU Plan. I authorize my employer, as my agent, to deduct from my pay or collect from me in advance the monthly rates therefore and remit such sums to the ISU Plan on my behalf. This authorization is to remain in effect until the ISU Plan is notified by my employer or me to the contrary. I understand that coverage for the contracts applied for will not start until after this application and the monies deducted from my pay for payment of the premium rates are received and accepted by the ISU Plan and an effective date is established by the ISU Plan. I understand that written notice of rate changes will be furnished by my employer as my agent.

I certify that, after this application was completed, I carefully and fully read it, that the statements and answers set forth are full, true, and correct to the best of my knowledge and belief, and that no information required to be given, either expressly or by implication has been knowingly withheld. I understand that the ISU Plan will rely on the completeness and truthfulness of the information given and the statements made, and that if I have made any false statements or misrepresentations, or have failed to disclose or concealed any material fact, the Plan will be entitled to declare the contracts applied for void and to refuse allowance of benefits to any person thereunder.

I authorize any health care provider to release health records to ISU Plan vendors and any reinsurers thereof when reasonably related to my or my dependent's receipt of health care/dental care which is covered under the contract for which I am applying. I understand that this information will be used only for legitimate business purposes including reports for regulatory authorities, annual health plan performance reports, health care research or studies or for health plan accreditation purposes in which my identity will be protected unless further authorization is obtained from me or an adult dependent. If any law or regulation requires additional authorization for release of health/dental records, I will give this authorization.

Signature _____ Date _____