Iowa State University
~ISU Plan 2015~
Post-Doctoral Associate Benefit Change Form~

Use this enrollment form to request a change in your ISU Plan Benefits.
When this form is completed, sign, date & return to: Benefits Office, 3810 Beardshear Hall, Ames IA 50011-2033.

Name: _____ **Previous Name (if changed):** _____

Address: _____ **University ID:** _____

City/ST/Zip: _____ **Date of Qualifying Event:** _____

Qualifying Event:	Marriage	Birth	Adoption	Fulltime Student	>Age 26	No longer fulltime student
(Circle One)	Death	Divorce	Other (Explain)			

Additional proof of event required? Yes No ***If yes, attach proof of event***

Name of person/s affected: _____

Address *(if Divorce):* _____

Office use only
Effective date:

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. See double spouse info below. Coordination of benefits (COB) may apply to other employer's plans.
Indicate current tier of coverage by circling appropriate section. Then circle your new tier of coverage in the new tier section.

HEALTH INSURANCE

	HMO	**PPO**
Current Tier	Opt Out	
	Yourself Only	Yourself Only
	Yourself & Spouse/Partner**	Yourself & Spouse/Partner**
	Yourself & Child(ren)	Yourself & Child(ren)
	Yourself & Family**	Yourself &Family**
New Tier	Opt Out	
	Yourself Only	Yourself Only
	Yourself & Spouse/Partner**	Yourself & Spouse/Partner**
	Yourself & Child(ren)	Yourself & Child(ren)
	Yourself & Family**	Yourself & Family**

DENTAL INSURANCE

	Basic	**Comprehensive**
Current Tier	Opt Out	
	Yourself Only	Yourself Only
	Yourself & Spouse/Partner **	Yourself & Spouse/Partner **
	Yourself & Child(ren)	Yourself & Child(ren)
	Yourself & Family**	Yourself & Family**
New Tier	Opt Out	
	Yourself Only	Yourself Only
	Yourself & Spouse/Partner **	Yourself & Spouse/Partner **
	Yourself & Child(ren)	Yourself & Child(ren)
	Yourself & Family**	Yourself & Family**

Each option and its price tag are listed on this form to inform you of the new costs.

Health & Pharmacy Insurance

Office Use only
Effective date:

Employee Monthly Share	**Yourself Only**	**Yourself & Spouse/Partner****	**Yourself & Child(ren)**	**Yourself & Family****
HMO (Blue Advantage) & Rx	$0.00	$78.00	$46.00	$112.00
PPO (Alliance Select) & Rx	$20.00	$263.00	$173.00	$339.00
Your *Double Spouse/Partner Share				
HMO (Blue Advantage) & Rx	N/A	N/A	N/A	$0.00
PPO (Alliance Select) & Rx	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 Consultants for option details.

****Partners and 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

Office Use only
Effective Date:

Employee Monthly Share	**Yourself Only**	**Yourself & Spouse/Partner****	**Yourself & Child(ren)**	**Yourself & Family****
Basic	$0.00	$30.00	$37.00	$45.00
Comprehensive	$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 Health & Pharmacy Insurance above for * double spouse information and **domestic partner, FTS >26 tax information. Same applies to dental.

Health and/ or Dental Insurance – YOU AND YOUR DEPENDENTS – List all on plan(s)

	Social Security Number or indicate Foreign National (FN)	Y/N ***Medicare Enrolled**	Name (Last, First, Middle Initial)	Birth Date	M/F Gender	Indicate Dependent Child status **when over 26:** **FTS**-unmarried, full time student **LTD**- unmarried, permanent disabled *(verified by Wellmark)*	**HMO MEMBERS ONLY** Primary Care Physician (PCP) Name/Code	Female Members MAY Designate Primary OB GYN
Yourself								
Spouse/ Partner								
Child								
Child								
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 an adult dependent or me. If any law or regulation requires additional authorization for release of health/dental records, I will give this authorization.

Signature _____ Date _____