ISEBA
every day, in every way, YOU come first

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: CENTRAL LYON

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 ____________________

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

	Reason	EFF. DATE OF CHANGE
☒	Open Enrollment	7/1/2020
☐	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) OPEN ENROLLMENT

Effective Date of Change: 07/01/2020

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