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Iowa Bankers Benefit Plan Health/Dental Insurance Application

Date processed: _____ Operator: _____

FOR BANK USE:
 Routing/Billing #: _____

ALL APPLICATIONS MUST BE RETURNED TO IBIS. Retain copy for your files.

<p style="text-align: center;">IS THIS APPLICATION DUE TO:</p> <p> <input type="checkbox"/> New employment <input type="checkbox"/> Part-time to Full-time (date _____) If nothing is checked, please include certificate of prior coverage. </p> <p> <input type="checkbox"/> Loss of other health coverage <input type="checkbox"/> Other (attach explanation) </p>	<p style="text-align: center;">INSTRUCTIONS- PLEASE TYPE OR PRINT LEGIBLY</p> <p>SINGLE Contract - Fill out PARTS A & C Read PART E, date & sign. Employee/Child(ren): EE/CH Employee/Spouse: EE/SP or FAMILY Contract - Fill out PARTS A, B & C. Read PART E, date & sign.</p> <p>EMPLOYEES DECLINING HEALTH COVERAGE- MUST fill out PARTS A & D and date & sign PART E.</p>
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A. EMPLOYEE NAME, ADDRESS AND COVERAGE

Name (Last) _____ (First) _____ (Initial) _____		Date of Birth _____	Social Security # _____		MEDICARE # if applicable _____	Effective Date _____	
Residence (No.) (Street or RFD No.) _____ (City) _____ (State) _____ (Zip) _____		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Unmarried		Date Employed _____		
Name of Employer (Bank) _____		Employer's Address (Main Office) _____		Bank Waiting Period <input type="checkbox"/> 1st of month after employment <input type="checkbox"/> 1st of month after 30 days	Employment Status <input type="checkbox"/> Full-time <input type="checkbox"/> Retiree <input type="checkbox"/> Part-time <input type="checkbox"/> Director	Job Title _____	
Contract Type: Check One HEALTH COVERAGE: <input type="checkbox"/> Single <input type="checkbox"/> EE/SP <input type="checkbox"/> EE/CH <input type="checkbox"/> Family		Plan Type: Check One <input type="checkbox"/> 250 <input type="checkbox"/> 1000 <input type="checkbox"/> 2000 <input type="checkbox"/> 5000/HSA <input type="checkbox"/> 500 <input type="checkbox"/> 1500 <input type="checkbox"/> 2000/HSA		Effective Date _____	Plan Type: Check One DENTAL COVERAGE: <input type="checkbox"/> Single <input type="checkbox"/> EE/SP <input type="checkbox"/> EE/CH <input type="checkbox"/> Family	Plan Type: Check One <input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 4	Effective Date _____

B. FAMILY CONTRACT INFORMATION

1. Spouse's Name (Last) _____ (First) _____ (Initial) _____		Social Security No. _____		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth _____		
2. Children Under 19, Students, or Disabled (List in order of age beginning with oldest child) _____ Check if applicable							
Name (Last, First, Initial)	Social Security No.	Date of Birth	Male	Female	Disabled	Student	If 19 or over, single, and a full-time student, give name and location of school
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does your spouse or anyone else named in this application have health/dental insurance through Medicare or another group where the employer pays any portion of the cost or make payroll deductions? <input type="checkbox"/> Yes If yes, complete the following: <input type="checkbox"/> Single <input type="checkbox"/> Health <input type="checkbox"/> Medicare <input type="checkbox"/> Yes Effective Date _____ Soc. Sec. Disabled? <input type="checkbox"/> Yes Medicare Enrolled? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Family <input type="checkbox"/> Dental <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No							
Name of Primary insured: _____		Employer _____		Carrier (Name) _____		I.D. Number with Carrier _____	

C. PRIOR COVERAGE INFORMATION

Did you have health coverage in the last 63 days? Yes No If yes, please complete the following:

Name of Ins. Co. _____ Policy No. _____

Covered Person(s) _____ Effective Date _____ End Date _____

D. WAIVER OF ENROLLMENT (Please complete if you are waiving health benefits)

I waive health coverage for my dependents and myself. Please indicate one of the following reasons:
 I (We) have coverage under another health care benefit plan. I (We) do not wish to enroll in the health plan.
Note: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependent in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

E. CERTIFICATE AND AGREEMENT

My signature verifies that I authorize any health care provider to release medical records for myself and all persons named herein to the Plan when reasonably related to the health care coverage for which application is being made for the purpose of enabling the Plan to accurately adjudicate benefit claims pursuant to the terms of my health care coverage. I further certify that I am duly authorized to give such consent to release medical records on behalf of all such persons named herein or eligible for coverage. I also agree that all rights contained by Section 622.10 Code of Iowa (1989) or similar laws or statutes forbidding any health care provider from disclosing any information, testifying or offering evidence, documentation or otherwise, when reasonably relating to the health care coverage for which I have applied, are waived for myself and all other persons named herein or eligible for coverage under the contracts for which application is made and I hereby certify that I am duly authorized to give such consent on behalf of all such persons. If any law or regulation requires additional authorization for release of medical records, I will give this authorization.

Date Signed: _____ Signature: _____

This policy is issued by a Multiple Employee Welfare Arrangement (MEWA). MEWA's are not subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your MEWA.

