

INSTRUCTIONS

THIS FORM IS TO BE USED TO REPORT CHANGES IN EMPLOYEE STATUS. Enter below only those items which have **CHANGED**. Enter the **DATE OF EVENT** on the left side and the new information in the appropriate space. Please use the **COMMENTS OR QUESTIONS** section for additional information. **YOU MUST SIGN AND DATE THE FORM.**

ALL CHANGES MUST BE REPORTED TO IBIS. Retain copy for your files.



IOWA BANKERS
 INSURANCE AND SERVICES, INC.

8800 NW 62nd Ave.
 PO Box 6210
 Johnston, IA 50131-6210
 1-800-258-1415
 (515) 286-4369 FAX
 www.bankers-ins.com

FOR OFFICE USE ONLY:

Date processed: _____ Assigned Effective Date: _____

**Iowa Bankers Benefit Plan
 Health/Dental Change Form**

Is your health/dental premium pre-taxed Yes No

BANK NAME _____ **CITY** _____ **ROUTING/BILLING #** _____

EMPLOYEE NAME (Last, First, Middle Initial) _____ **SOCIAL SECURITY NUMBER** _____

A.

DATE OF EVENT	COVERAGES: Requested Effective Date	Check One	Action or Instructions
_____	HEALTH _____	<input type="checkbox"/> Single <input type="checkbox"/> EE/CH <input type="checkbox"/> EE/SP <input type="checkbox"/> Family	_____
_____	DENTAL _____	<input type="checkbox"/> Single <input type="checkbox"/> EE/CH <input type="checkbox"/> EE/SP <input type="checkbox"/> Family	_____

EE/CH: EMPLOYEE/CHILD(REN) EE/SP:EMPLOYEE/SPOUSE OR FAMILY COVERAGE: ADDITIONS/DELETIONS FOR ALL PLANS LIST UNDER PART D AND/OR PART E

B.

EMPLOYMENT STATUS: Full-time Part Time

Termination Date: _____ 'COBRA status' forms are attached Forthcoming

Retirement Date: _____

Continue Retiree Health Yes No Continue Retiree Dental Yes No Date of Death: _____

C.

Legally Separated Date: _____ Death of Spouse

MARITAL STATUS Unmarried Date: _____ Married Date: _____ Employee's previous Last name: _____

D.

ADD REMOVE

SPOUSE: Name _____ Social Security # _____

Sex: Male Female Disabled: Yes No Date of Birth: _____

Employed: Yes No Other Insurance: Yes No (If yes, please fill out OTHER INSURANCE in Part F.)

E.

ADD REMOVE CHANGE

CHILDREN: (For students, give school name in comments section. If disabled, give Medicare effective dates and date of disability.)

Name (Last, First, Middle)	SSN	Date of Birth	Sex	Student	Disabled
_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>

Reason for removing dependant _____

F.

ADD REMOVE

OTHER INSURANCE:

Person	Employer	Carrier	ID #
_____	_____	_____	_____

Medicare Number _____ Part A Effective Date _____ Part B Effective Date _____

G.

ADDRESS: Street: _____

City: _____ State: _____ Zip Code: _____

COMMENTS OR QUESTIONS: _____

Date Signed: _____ Employee Signature: _____ Phone No.: _____