



IOWA BANKERS

INSURANCE AND SERVICES, INC.

8800 NW 62nd Ave, PO Box 6210

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Ph: 800-258-1415 • 515-286-4369 fax

LIFE/DISABILITY COVERAGE APPLICATION and/or CHANGE FORM

THIS IS A: NEW ENROLLMENT CHANGE TERMINATION

APPLICATION

EMPLOYER BANK		CITY	STATE	BANK ROUTING/BILLING #
SOCIAL SECURITY NO.	EMPLOYEE NAME-LAST		FIRST	MIDDLE INITIAL
STREET ADDRESS		CITY	STATE	ZIP
SEX- M F	MARITAL STATUS- () SINGLE () MARRIED		WORK PHONE #	
BIRTH DATE	DATE EMPLOYED	COVERAGE EFFECTIVE DATE (FOR OFFICE USE ONLY)		
JOB TITLE			ARE YOU A BANK OFFICER? YES NO	
BASE EARNINGS \$ _____ <input type="checkbox"/> HR <input type="checkbox"/> WK <input type="checkbox"/> MO <input type="checkbox"/> YR HOURS WORKED EACH WEEK _____				
I AM APPLYING FOR: <input type="checkbox"/> GTL <input type="checkbox"/> DL <input type="checkbox"/> STD <input type="checkbox"/> LTD			<input type="checkbox"/> ADDL - OPTIONAL ADDITIONAL LIFE AT _____ X MY ANNUAL SALARY (ENTER 1, 2, OR 3)	
OPTIONAL ADDL DL SPOUSE COVERAGE- <input type="checkbox"/> \$35,000 <input type="checkbox"/> \$50,000 requires Medical History Statement			2 or 3 Requires Medical History Statement	

WAIVER

[WAIVER OF BENEFIT] THE GROUP INSURANCE AVAILABLE TO ME THROUGH MY EMPLOYER HAS BEEN EXPLAINED TO ME. AFTER CAREFUL CONSIDERATION I HAVE DECIDED THAT I DO NOT WANT TO ENROLL IN ONE OR MORE PLANS.

I WISH TO WAIVE MY RIGHT TO AND NOT APPLY FOR: GTL DL STD LTD ADDL

I UNDERSTAND THAT IF I WANT TO BECOME INSURED LATER I WILL BE REQUIRED TO PROVIDE INSURING COMPANY WITH SATISFACTORY EVIDENCE OF INSURABILITY AND THAT INSURING COMPANY WILL HAVE THE RIGHT TO REFUSE MY REQUEST FOR INSURANCE.

BENEFICIARY

PLEASE CHECK IF CHANGE OF NAME AND/OR BENEFICIARY Effective Date: _____
BENEFICIARY CHANGE-COVERAGES EFFECTED BY CHANGE: GTL ADDL

PRIMARY BENEFICIARY	NAME (LAST)	(FIRST)	(MIDDLE INITIAL)	RELATIONSHIP	AGE
CONTINGENT BENEFICIARY (1ST)	NAME (LAST)	(FIRST)	(MIDDLE INITIAL)	RELATIONSHIP	AGE
(2ND)					
(3RD)					

TERMINATION

TERMINATION OF COVERAGE IS DUE TO:
 _____ TERMINATION OF EMPLOYMENT TERMINATION DATE: _____
 _____ REDUCTION IN NUMBER OF HOURS DATE OF EVENT: _____

EFFECTIVE DATE OF TERMINATION COVERAGE: _____

PLEASE TERMINATE THE FOLLOWING COVERAGES: GTL DL STD LTD ADDL

Date: Mo. Day Year	Signature of Employee:
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***Application or Change Form MUST be signed and dated by employee to be valid.**

IBIS - 008-(9/07) RETAIN COPY FOR YOUR RECORDS

