

# Iowa State University 2006 Benefit Change Form ISU Greek Affairs

Name: \_\_\_\_\_

Effective Date: \_\_\_\_\_

Address: \_\_\_\_\_

University ID: \_\_\_\_\_

City: \_\_\_\_\_

State/Zip: \_\_\_\_\_

This is your ISU Plan enrollment form for coverage 2/1/06 or eligible start date through 1/31/07 or end date. Please circle the coverage(s) you wish to enroll in, complete the information at the bottom, sign and date.

Please circle premium cost of your NEW selection only.

### Your Monthly Medical Premium Rates

### Your Monthly Dental Premium Rates

Plan Tier
Yourself
Yourself & Spouse
Yourself & Child(ren)
Yourself and Family

HMO	PPO
\$324.00	\$351.00
\$744.00	\$804.00
\$582.00	\$627.00
\$947.00	\$1029.00

Basic Plan	Comprehensive Plan
\$20.00	\$32.00
\$45.00	\$80.00
\$50.00	\$86.00
\$56.00	\$96.00

## MEDICAL/DENTAL INSURANCE – YOU AND YOUR DEPENDENTS

	Social Security #	Name (Last, First, Middle Initial)	Birth Date	Gender (M/F)	Primary Care Physician Code (HMO only) Use code # from directory or web site:	Primary Care Physician- You must select a Primary Care Physician – HMO only  <a href="http://www.healthalliance.org">www.healthalliance.org</a>
Yourself						
Spouse/Partner						
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. No statute or other authority requires that you disclose your SSN for that purpose. Failure to provide you SSN, however, may result in administration difficulties. 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.

### 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 ISU Plan's third party administration 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 me or my employer 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 medical records to ISU Plan vendors and any re-insurers 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 me or an adult dependent. If any law or regulation requires additional authorization for release of medical/dental records, I will give this authorization.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Return to ISU Benefits Office, 3770 Beardshear Hall, Ames IA 50011-2033.**