

GROUP INSURANCE ENROLLMENT FORM



EMPLOYER INFORMATION

EMPLOYER'S FULL LEGAL NAME

UNIVERSITY OF IOWA COMMUNITY MEDICAL SERVICES, INC

ENROLLMENT INFORMATION

OFFICE USE ONLY

OCC CODE

CLASS

LIFE/AD&D

LTD

STD

EFF. DATE

PLEASE CHECK ONE OF THE BOXES BELOW:

20176039

INITIAL ENROLLMENT CHANGE TO EXISTING ENROLLMENT

NAME / ADDRESS CHANGE (FORMER NAME _____)

BENEFICIARY CHANGE (LIFE/AD&D SUPPLEMENTAL LIFE)

COVERAGE CHANGE (ADD _____ DELETE _____ EFFECTIVE DATE _____)

FAMILY STATUS CHANGE (TYPE _____ EFFECTIVE DATE _____)

EMPLOYEE INFORMATION

EMPLOYEE'S NAME (LAST, FIRST, MIDDLE INITIAL)

DATE OF BIRTH

GENDER

MARITAL STATUS

SOCIAL SECURITY NUMBER

EMPLOYEE'S HOME ADDRESS

CITY

STATE

ZIP

OCCUPATION

EARNINGS (AS DEFINED BY THE POLICY) HR MO YR

HOURS WORKED PER WEEK

DATE OF HIRE

SPECIALTY (IF A PHYSICIAN):

Class 1 – Physicians, Exec. Directors, & Operations Manager

Class 2 – All Other Active Full-Time Employees

Class 3 – Part-Time Physicians working 20-29 hours per week

Class 4 – All Other Active Part-Time Employees working 20-29 hours per week

BENEFICIARY INFORMATION

PRIMARY LIFE BENEFICIARY NAME

RELATIONSHIP

DATE OF BIRTH

SOCIAL SECURITY NUMBER

% OF BENEFIT

PRIMARY LIFE BENEFICIARY NAME

RELATIONSHIP

DATE OF BIRTH

SOCIAL SECURITY NUMBER

% OF BENEFIT

CONTINGENT LIFE BENEFICIARY NAME

RELATIONSHIP

DATE OF BIRTH

SOCIAL SECURITY NUMBER

% OF BENEFIT

Note: If additional space is needed, use back of form. Your beneficiary designation can be changed at any time. If you are married and/or divorced and reside in a community property state, you should consult with your legal counsel prior to changing your beneficiary. The designation takes effect as of the date the completed form is received and accepted by MGIS.#

APPLICABLE BENEFIT ELECTIONS

Please make your benefit elections by checking the appropriate box. Contact your employer for plan details.

LONG TERM DISABILITY YES * LTD coverage for Class 1 & 2 employees only.

LIFE & AD&D YES

SPOUSE INFORMATION

SPOUSE'S NAME

SPOUSE'S GENDER

SPOUSE'S SOCIAL SECURITY NUMBER

SPOUSE'S DATE OF BIRTH

APPLICATION FOR COVERAGE

I apply for the group insurance coverage checked above provided under my employer plan. I authorize deductions from my wages to cover my contribution, if required. If I have declined any contributory coverages for which I am eligible above, I understand that to later enroll for these coverages satisfactory medical evidence of insurability will be required and the insurance carrier will have the right to refuse my request. Any person who knowingly, and with the intent to defraud or deceive any insurance company, submits an insurance application containing any false, incomplete or misleading information may be subject to civil or criminal penalties, depending upon state law.

EMPLOYEE SIGNATURE

DATE

DECLINATION OF COVERAGE (IF APPLICABLE)

I refuse the contributory coverages offered by my employer. 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 for the plans offered above. I understand that if I choose not to enroll for all of the coverages for which I am eligible, within 31 days after I become eligible, satisfactory medical evidence of insurability will be required and the insurance carrier will have the right to refuse my request.

EMPLOYEE SIGNATURE

DATE

Please keep a copy of the original enrollment forms and any updates with your employee files and submit a copy to:

MGIS*, P.O. Box 16110, Salt Lake City, UT 84116-0110 • Fax: 801.990.2401 • Phone: 800.969.6447