Employee Benefit Systems
P.O. Box 1053
Burlington, IA 52601
(319)752-3200
(800) 373-1327

Enrollment/Change Application

☐ New Application
☐ Change
☐ Cobra

DO NOT COMPLETE SHADED AREA

GROUP	LOCATION	EFFECTIVE DATE	COBRA	DATE

A. NAME/ADDRESS

NAME (LAST) FIRST (INITIAL)	TELEPHONE	SOCIAL SECURITY #	BIRTHDATE / /	FULL TIME HIRE DATE
RESIDENCE (NO.) (STREET OF RFD NO.) (CITY) (STATE) (ZIP)		OCCUPATION	SEX ☐ MALE ☐ FEMALE	MARITAL STATUS ☐SINGLE ☐ MARRIED

Employer Name ____________________

B. IF APPLYING FOR FAMILY COVERAGE LIST SPOUSE AND UN-MARRIED ELIGIBLE CHILDREN

NAME (FIRST) (INITIAL) (LAST)	MALE OR FEMALE	Relationship	Resides with insured	BIRTHDATE MO. DAY YR.	SOCIAL SECURITY NUMBER	Student or disabled	Medicare I.D. No. or College/Trade School
	☐ M ☐ F	SPOUSE	☐ YES ☐ NO	/ /		☐ Disabled ☐ Student	
	☐ M ☐ F		☐ YES ☐ NO	/ /		☐ Disabled ☐ Student	
	☐ M ☐ F		☐ YES ☐ NO	/ /		☐ Disabled ☐ Student	
	☐ M ☐ F		☐ YES ☐ NO	/ /		☐ Disabled ☐ Student	
	☐ M ☐ F		☐ YES ☐ NO	/ /		☐ Disabled ☐ Student	

USE SPACE BELOW FOR CHANGES AFFECTING EXISTING MEMBERSHIP

☐ MARRIAGE ☐ DIVORCE ☐ BIRTH ☐ DEATH ☐ OTHER	NAME OF AFFECTED PERSON	DATE OF EVENT

C. OTHER INSURANCE INFORMATION

Are you, your spouse or dependent(s) enrolled in :

Any other health insurance? YES NO ____________________
Medicaid (Title XIX)? YES NO ____________________
Medicare YES NO ____________________

If YES to any of the above, please complete below:

Name of insured family member	Employer (If Applicable)	Name/HMO Group	Policy Number	Effective Date	Medicare Eff. Date	Medicaid Eff. Date

D. LEGAL PROVISIONS

1) Do all children listed depend on you for more than 50% of their financial support? YES NO If no, list who does not: ____________

2) Will you claim all of the above children on this year's income tax return? YES NO If no, list who will not be claimed: ____________

3) Do all the children listed above reside with you more than 6 months a year? YES NO

If you answered "NO" to #3 above, provide the following custody information:

Dependent Name:	Custody Arrangement
	☐ Joint custody - less than 6 months per year ☐ Visitation rights ☐ No contact
	☐ Joint custody - less than 6 months per year ☐ Visitation rights ☐ No contact
	☐ Joint custody - less than 6 months per year ☐ Visitation rights ☐ No contact

4) Does a divorce decree or court order make provisions as to who is responsible for health insurance/tax exemptions for any of the dependent children?
Yes No If yes, please provide a COPY of the section of the divorce decree or court order relating to tax exemptions and insurance.

E. OPT OUT OF COVERAGE

I certify that I have been informed that an employer sponsored Group Health Care Benefit Plan is available to me through my employer.

I have voluntarily opted out of ☐**Medical** ☐**Rx** ☐**Dental** ☐**Vision** coverages, (if applicable, and understand that re-entry is subject to the re-enrollment and eligibility rules of the Plan. (See Agreement and Certification information on reverse side of this enrollment form)

If opting out of coverage, please check one box below if applicable, and complete Section C.

☐ I am covered by my spouse's Group Plan through his/her employer (Complete Section C)
☐ I am covered by my self-employed spouse's plan (Complete Section C)

DATE **SIGNATURE**

F. AGREEMENT

I have read and understand the Agreement and Certification information on the back of this Enrollment Form and acknowledge receipt of a fully completed copy of this application.

DATE **SIGNATURE**

White: EBS Yellow: Employer Pink: Employee