



THE UNIVERSITY OF IOWA

2012 TEMPORARY INSURANCE FOR FACULTY OR P&S EMPLOYEE

Employee's Name: _____ Employee ID/University ID#/or SSN _____

Department: _____ Campus Address: _____

First day of insurance: _____ (month/year)

Last day of insurance: _____ (month/year)

Please check the appropriate box below to indicate the department's monthly contribution toward the cost of this staff member's insurance. Insurance rates adjust every January.

Health Coverage	UI Contribution per month (UI Choice / CHIP II)	Full Contribution per month (UI Choice / Chip II)
<input type="checkbox"/> Employee	\$476 / 593 (Full contribution)	
<input type="checkbox"/> Employee/spouse	\$885 / 885	<input type="checkbox"/> Employee/spouse \$1,106 / 1,326
<input type="checkbox"/> Employee/children	\$728 / 613	<input type="checkbox"/> Employee/children \$ 910 / 613
<input type="checkbox"/> Family	\$931 / 931	<input type="checkbox"/> Family \$1,163 / 1,448

Dental Coverage	UI Contribution per month (Dental 1 / Dental 2)	Full Contribution per month (Dental 1 / Dental 2)
<input type="checkbox"/> Employee	\$30 / 49 (Full contribution)	
<input type="checkbox"/> Employee/spouse	\$48 / 76	<input type="checkbox"/> Employee/spouse \$60 / 95
<input type="checkbox"/> Employee/children	\$60 / 80	<input type="checkbox"/> Employee/children \$75 / 100
<input type="checkbox"/> Family	\$75 / 104	<input type="checkbox"/> Family \$93 / 129

This amount is to be charged to the following

FUND	ORG	DEPT	SDEPT	GRTPROG	IACT	OACT	DPACT	FN	CCTR

Authorized Signature: _____ Date: _____

Printed Name: _____

Campus Phone: _____

The department's contribution selection must be the same as the employee's coverage selection. For example, if the department will only contribute towards a single plan, then the employee can only elect single coverage. If the employee chooses a plan which costs more than the department's contribution, then the University Business Office will bill the employee for the excess amount. For example, the family contribution will not cover the entire cost of family coverage. The employee will be billed for the difference.

Please return this form to:

Mary Eggenburg
University Benefits Office
120-40 University Services Building

If you have any questions, please call 335-2674 or email mary-eggenburg@uiowa.edu.

[08-865]
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Office Use

Packet mailed _____
 Month coverage ended _____
 COBRA paperwork requested _____

Date: _____

Accounting Adj. _____ Yes _____ No