



20%
**REQUEST FOR PAYMENT OF HEALTH INSURANCE CONTRIBUTIONS
 FOR A TEMPORARY FACULTY OR P&S EMPLOYEE**

Employee's Name: _____ Employee ID/University ID#/or Social Security # _____

Department: _____ Campus Address: _____

First day of insurance: _____ (month)

Last day of insurance: _____ (month)

Please check the amount that the department will contribute per month towards the cost of this staff member's health insurance. Dental insurance is optional.

Health Coverage:

- Single \$411.00/month
- Employee/spouse \$151.00/month
- Employee/children \$511.00/month
- Family \$711.00/month

Dental Coverage:

- Single \$211.00/month
- Employee/spouse \$400/month
- Employee/children \$57.00/month
- Family \$611.00/month

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 e-mail mary-eggenburg@uiowa.edu.