Sick Leave Insurance Program Enrollment Form

Employee Name	
Department	
Date of Birth	
Age at Termination	
Requested IPERS First Payment Date	

Affirmations
I meet the eligibility requirements for the Sick Leave Insurance Program (Program) by being eligible for and *receiving a monthly retirement benefits from the Iowa Public Employees' Retirement System.*

I understand that I will remain eligible for this Program until one of the following occurs:

- I accept permanent employment with the State of Iowa;
- I fail to pay any employee share amount due;
- I stop participating in the State's group health insurance program;
- I become eligible for Medicare;
- My sick leave insurance account is depleted; or
- I die.

I understand that this Program will pay the employer's share of state health insurance that would otherwise be paid for by the State if I were still a state employee. I understand that I may be required to pay a percentage of the health insurance premium in order to participate in this Program and I understand that this required amount may change subject to Iowa law, policy, or any applicable Collective Bargaining Agreement (CBA) provisions. I understand that I will be notified prior to the start of each plan year of the health insurance premium percentage I may be required to pay. I cannot use these funds to pay for the State's group dental program or for private insurance.

I understand that if I become reinstated in a permanent full-time or permanent part-time position, become eligible for Medicare, or die before my account is exhausted, my balance is not transferable. The remainder will be forfeited.

I understand that if my employer and I agree to extend or alter my effective date of retirement, I must complete a new Sick Leave Insurance Program Enrollment Form and give it to my Department Human Resources Associate prior to my last day of work.

I, the undersigned employee, and the State of Iowa agree as follows:

Section 1 – Parties
(a) For purposes of this Enrollment Form, the "State" refers collectively to the State of Iowa, its branches, departments, agencies, commissions, boards, offices, or other entities of state government, including its elected officials.

(b) I, the undersigned employee, am an eligible and participating employee in the Program.

Section 2--Benefits and Termination of Employment
(a) The State promises that I will receive the benefits for which I am eligible under the Program in exchange for this Enrollment Form and my voluntary retirement from employment. I acknowledge that I will not be entitled to receive any of these benefits unless I sign this Enrollment Form. These benefits will be paid according to the provisions of the Program, as provided in the applicable collective bargaining contract or legislation and administrative rules, but only if I do not revoke this Enrollment Form, which I may do prior to my date of termination from employment.

(b) I understand that the State reserves the right to suspend or terminate the Program; to modify the Program to provide different cost sharing between the State and participants; or to amend the Program in any respect. I understand that changes may occur at any time, subject to Iowa law or any applicable Collective Bargaining Agreement (CBA) provisions.

(c) I understand that I am eligible for any plan that the State should make available to me. I understand that this Program will pay the employer's share of state health insurance that would otherwise be paid for by the State if I were still a state employee and further understand that I may be required to pay a percentage of the premiums directly, regardless of my SLIP balance. I understand that the percentage I am required to pay may change at any time, subject to Iowa law or any applicable Collective Bargaining Agreement (CBA) provisions. I acknowledge that I may be eligible to participate in the State's wellness plan while I participate in this Program.

(d) I agree that my employment with the State has ended or will end on the date agreed to by me and the State. I agree and understand that if I return to permanent employment with the State, or to a temporary position with the State that has not been approved by the Department of Administrative Services, I am no longer eligible for the benefits of this Program. I acknowledge that no one has pressured or coerced me into retiring or participating in the Program. I further acknowledge that no one made any representations to me (other than the representations contained in the official written documents for the Program and the official website) about the Program or about benefits or programs that the State may or may not offer in the future. I further acknowledge I am not entitled to rely upon written or verbal representations made to me other than contained in the official Program documents.

(e) I affirm that I meet the eligibility requirements to participate in the Program and I acknowledge it is my responsibility to confirm or make sure that I am eligible for the Program.

Section 3 –Release
I hereby release the Iowa Public Employees' Retirement System to provide information to the Department of Administrative Services and the Department of Management for the purposes of verifying my initial and continuing eligibility for this Program.

Section 4 – Entire Agreement
This Enrollment Form is the entire agreement between me and the State. This Enrollment Form may not be modified or canceled in any manner, other than revocation by me, unless made in writing and signed by both me and an authorized State official of the employing agency and the Iowa Department of Administrative Services. I agree and understand this Enrollment Form is not an admission of guilt or wrongdoing by either myself or the State. I acknowledge that the State has made no promises to me other than those in this Enrollment Form. If any provision in this Enrollment Form is found to be unenforceable, all other provisions will remain fully enforceable. The State is not required to sign this Enrollment Form for it to become binding upon both me and the State.

PLEASE READ BEFORE SIGNING

TAKE THIS ENROLLMENT FORM HOME, READ IT, AND CAREFULLY CONSIDER ALL OF ITS PROVISIONS BEFORE SIGNING IT.

YOU MAY SUBMIT THE SIGNED ENROLLMENT FORM AT ANY TIME PRIOR TO YOUR RETIREMENT. TO PARTICIPATE IN THE PROGRAM, YOU MUST SIGN AND SUBMIT THIS ENROLLMENT FORM TO YOUR PERSONNEL ASSISTANT ON OR BEFORE YOUR RETIREMENT DATE.

SIGN HERE IN INK: _____ **DATE:** _____

For Human Resources Associate Use Only

IPERS File Date: _____ - _____ - _____
Last Day Scheduled to Work: _____ - _____ - _____

Send a copy of this completed form to Department of Administrative Services – Human Resources Enterprise as soon as it is completed. Keep the original in the employee's personnel file.