Iowa Department of Administrative Services

REFUND FOR HEALTH, DENTAL, LIFE AND LTD INSURANCE

Employee Name: ______________________________

Department Name: ______________________________

Date Submitted: ______________ **Pay Periods of Over-deduction:** ______________

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10 Digit Payroll Number*	Class and Position Numbers	Employee Number	Social Security Number (Required)	Insurance Type (H, D or L)

Date** (MM-YY)	Insurance Code Being Refunded	Pre-Tax Flag (Y or N)	Refund Amount For Employee	Refund Amount For State Share	Reason for Refund (Code)

Explanation:***

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* *Payroll number must correspond to billing report at over-deduction.*
** *Date - include MM and YY of effective date to which the refund applies.*
*** *Always include a full explanation regardless of refund reason.*

Insurance Type

H = Health
D = Dental
L = Life or LTD

Pre-Tax Flag

Y = Yes Pre-Tax
N = No Pre-Tax
(Can be found on PAYL or V1 screen in EI module)

Reason for Refund

1 = Termination of Employment
2 = Termination of Insurance Coverage Only
3 = LTD Leave
4 = Transfer Between Plans
5 = Incorrect Code
6 = Part-time to Full-time
7 = Other Reason

NOTE:

Include a separate form for each type of insurance refund (i.e., health, dental, life, LTD) for each employee. Always include a full explanation regardless of refund reason.

Authorized Claim Signature ______________________________

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