Application for the Retired/Disabled Health and Dental Insurance Group

1. Name: _____
2. Home Address: _____
3. Email: _____
4. Last 4 of Social Security Number: _____ 5. Date of birth: _____
6. Phone Number: _____
7. Last Day Worked: _____
8. Is any person to be covered Medicare eligible? ☐ Yes ☐ No

I understand to be eligible for Retiree benefits: **Initial** _____

- I must be age 55 prior to my last day worked.
- I must be the policy holder.
- I must take my IPERS payments directly after termination.

I understand if any of the following happen after I retire, I need to contact Retiree Services at either 515.281.6124 or stateretirees@iowa.gov: **Initial** _____

- If I or anyone covered becomes Medicare eligible prior to age 65
- To add, remove, change or cancel coverage.
- Update address

For Health Insurance, I select:		
☐ **Waive Coverage**		
☐ **Iowa Choice**	☐ Single	☐ Family
☐ **National Choice**	☐ Single	☐ Family
☐ **Group Program F**	☐ **Group Program F Dependent**	
☐ **Group Program N**	☐ **Group Program N Dependent**	

For Dental Insurance, I select:		
☐ **Waive Coverage**		
☐ **Delta Dental**	☐ Single	☐ Family

Signature: _____ Date: _____

For HRA Use Only

Type of Retirement: **(Select One)**

☐ SLIP ☐ Regular ☐ LTD ☐ Resigning General Assembly Member

Effective date of Retirement: _____ IPERS File date: _____

Confirm Retiree is Policy Holder: **(Select One)** ☐ Yes ☐ No

HRA Name: _____HRA phone number: _____

Forms included: **(Select which forms are attached)**

☐ Health ☐ Dental ☐ EFT ☐ MedicareBlue Rx ☐ EFT