

# STATE OF IOWA – CENTRALIZED PAYROLL HEALTH AND DENTAL INSURANCE TRUSTEE REPORT ADJUSTMENTS

FOR MONTH OF \_\_\_\_\_ INS. CARRIER \_\_\_\_\_ DATE COMPLETED \_\_\_\_\_ PAGE \_\_\_\_\_ OF \_\_\_\_\_  
 THREE DIGIT DEPT. NUMBER \_\_\_\_\_ DEPT. NAME \_\_\_\_\_ DATE OF REVISION #1 \_\_\_\_\_  
 DATE OF REVISION #2 \_\_\_\_\_

							TOTAL PREMIUM AMOUNT	NO. OF EMPLOYEES COVERED
AMOUNTS SHOWN ON TRUSTEE REPORT (Summary Report Totals)								
NAME	SSN (Required)	INSURANCE CODE		EXPLANATION (INCLUDE DATES)	+/-	CHANGE IN DOLLARS	+/-	CHANGE IN EE COUNT
		FR*	TO					
<b>CORRECTED TOTALS</b>								

\*Incorrect code on the Billing Report that the employee is changing from or is being refunded.