IOWA DEPARTMENT OF ADMINISTRATIVE SERVICES

STATE SHARE TRANSFER

Department Name: _____ **Date:** _____

Employee Name: _____ **SSN:** _____

Payroll Number: _____

Reason for Transfer: _____

_____

_____

Enter only <u>one</u> employee name, plan name, insurance code and dollar amount per request.
All fields on form must be completed, or request may be returned due to insufficient information.

Insurance Carrier: _____ **Amount:** _____

Insurance Code: _____

For Month of: _____

Authorized by: _____