IOWA DEPARTMENT OF ADMINISTRATIVE SERVICES

STATE SHARE TRANSFER

|  |  |  |  |
| --- | --- | --- | --- |
| **Department:** |       | **Date:** |       |
|  |
| **Employee Name:** |       | **SSN:** |       |
|  |
| **Payroll Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  |
|  |
| **Reason for Transfer:**        |

*Enter only one 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 Plan: |       | Amount: |       |
|  |  |  |  |
| Insurance Code: |       |  |  |

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| **For Month of:** |       |  |  |  |

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| CFN 552-0335 R 4/04 |  | **Authorized by:** |       |

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| Insurance Plan: |       | Amount: |       |
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