IOWA STATE UNIVERSITY
OF SCIENCE AND TECHNOLOGY

University Human Resources
Employee Benefits Office
3810 Beardshear Hall
515 Morrill Road
Ames, Iowa 50011-2103
515 294-4800
Toll Free 877 477-7485
FAX 515 294-8226

1. Insurance Contract holder name: _____ University ID: _____

2. Your dependent's name and date of birth: _____

3. Is this dependent married? ____ No   ____ Yes   If yes, please provide the date of marriage: _____

4. Is dependent a full time student?
   ___ No   If no, please provide the last date attended as a fulltime student: _____

   ___ Yes   If yes, please provide the name and address of the school:
   _____

5. Is dependent on a physician-certified leave of absence from an institution of higher learning?

   ____ No   ____ Yes
      If yes, please provide a copy of the leave of absence certification completed by the student's treating
      physician, including the date the leave of absence began.

Iowa State University requires a determination of total and permanent disability for a child to remain insured by
the parent's ISU Plan after age 26.

6. Is your dependent totally and permanently disabled as defined by a physician?   ____ No   ____ Yes

   When did the disability occur? _____
   Was your dependent considered disabled by another insurance carrier? _____
   If yes, name of insurance carrier: _____

   Please return a doctor's statement of verification that your dependent, reaching age 26, has a total and
   permanent (zero or close to zero chance of improvement) disability and your dependent is unable to
   support themselves or work in their own or any occupation for which they are suited by training,
   education, or experience.

   If enrolled for Medicare Disability coverage, please indicate:
   Medicare Number: _____   Effective date (Part A): _____   Effective date (Part B): _____

To the best of my knowledge, all statements and answers above are complete and true. I understand that fraud or a
material misrepresentation regarding dependent eligibility for coverage will result in termination retroactive to the date
eligibility was lost and I will be responsible for the cost of services provided during the period when coverage was in
effect while dependent above was not eligible for coverage.

_____   _____
Signature of Member   Date