**Shape, circle

Description automatically generatedGROUP SUPPLEMENTAL HEALTH INSURANCE APPLICATION**

**Intergovernmental Personnel Benefit Cooperative** **(IPBC)**

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| **Supplemental Health Insurance** |
| **Member Group Name:**  **Effective Date of Coverage:**  **Enrollment Effective Date:** |

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| **Lines of coverage that will be offered:** |
| **Supplemental Health**  **Coverage Type**  Confirm funding for each line of coverage below.  **Accident**  Employee Paid  Employer Paid  Employee and Employer Paid  - If both Employee and Employer Paid funding, please provide details:  **Critical Illness**  Employee Paid  Employer Paid  Employee and Employer Paid  - If both Employee and Employer Paid funding, please provide details:  **Hospital Indemnity**  Employee Paid  Employer Paid  Employee and Employer Paid  - If both Employee and Employer Paid funding, please provide details: |