**GROUP 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:       |