

LSU System Voluntary Benefits Enrollment Summary Sheet

* Enrollment into a health plan requires the completion of a GB-01 Form.

Employee Name: _____
Employee ID/SSN: _____
Employee Date of Birth: _____
Hire Date: _____
Hours Worked/Week: _____
Employee E-Mail Address: _____

For Office Use Only	
Effective Date:	
HR/Payroll Rep:	
Pay Type:	
Campus Code:	

If you are electing coverage, indicate which Level of Coverage you wish to enroll for each Voluntary Benefit listed below by placing a check mark in the appropriate box. Be sure to complete the Employee and Spouse and/or Dependent Sections on the following form if you are electing coverage that will cover you and your spouse, and/or dependents. You will be considered a timely applicant if you enroll within thirty (30) days from your date of hire; you will be considered a late applicant if you enroll after thirty days from your date of hire (see Your Employee Benefits Book for effective dates and requirements regarding Timely/Late Applicants). Descriptions of each Plan and applicable monthly premium can be found in Your Employee Benefits Book.

NOTE: Enrollment in Long Term Care, Group Term Life Insurance and the Tax-Saver Flexible Benefit Plans requires the completion of additional forms.

AD&D Insurance		
Please check which level of coverage you would like and indicate the Benefit Amount below (found in Your Employee Benefits Book)		AD&D Beneficiary Designation
Level of Coverage	Monthly Premium	Primary Name: _____ Relation: _____ % of Benefit: _____
<input type="checkbox"/> Employee Only	See Benefits Book for Premiums and Benefit Amounts	1 _____
<input type="checkbox"/> Family		2 _____
Complete Benefit Amount/Monthly Premium: AMT \$ _____ /PREMIUM \$ _____		Contingent Name: _____ Relation: _____ % of Benefit: _____
		1 _____
		2 _____

Dental Enhanced Plan (Option 1)			
	Level of Coverage	12 Month Monthly Premium	9 Month Monthly Premium
<input type="checkbox"/>	Employee Only	\$28.08	\$37.44
<input type="checkbox"/>	Employee + Spouse*	\$55.20	\$73.60
<input type="checkbox"/>	Employee + Child(ren)	\$67.16	\$89.54
<input type="checkbox"/>	Family	\$94.28	\$125.70

Long Term Disability	
Coverage	See Monthly Premium Calculation Below
<input type="checkbox"/> Yes, I would like to enroll in Long Term Disability	
\$ _____ x .005533 = \$ _____	
Monthly Salary	Monthly Premium

* Spouse's Dental Carrier (if any): _____

Dental Basic Plan (Option 2)			
	Level of Coverage	12 Month Monthly Premium	9 Month Monthly Premium
<input type="checkbox"/>	Employee Only	\$16.72	\$22.29
<input type="checkbox"/>	Employee + Spouse*	\$31.64	\$42.18
<input type="checkbox"/>	Employee + Child(ren)	\$43.84	\$58.45
<input type="checkbox"/>	Family	\$58.76	\$78.34

Vision Insurance			
	Level of Coverage	12 Month Monthly Premium	9 Month Monthly Premium
<input type="checkbox"/>	Employee Only	\$8.29	\$11.05
<input type="checkbox"/>	Employee + Spouse	\$13.96	\$18.61
<input type="checkbox"/>	Employee + Child(ren)	\$14.26	\$19.01
<input type="checkbox"/>	Family	\$22.98	\$30.64

* Spouse's Dental Carrier (if any): _____

PREMIUM ONLY PLAN for Health, Dental and Vision Insurance Premiums	
Elections for the Premiums Only Plan will automatically renew each year unless changed during Annual Enrollment in April with a July 1 effective date.	
<input type="checkbox"/>	YES, I elect to PARTICIPATE in the Premiums Only Plan. I understand that eligible insurance premiums will be deducted pre-tax and this election will remain in effect and cannot be cancelled or changed during the Plan Year unless the cancellation or change is within the guidelines of The LSU System Flexible Benefits Plan.

IMPORTANT NOTE: The Voluntary Benefits below require that you complete a SEPARATE enrollment form. The Term Life Insurance Form and Tax-Saver Flexible Benefit Plan Forms are attached in Your Employee Benefits Book; if you are interested in the Long Term Care Benefit, please indicate below and your local HR/Benefit Staff will send you more information.

Long Term Care	
<input type="checkbox"/>	Yes, I am interested in receiving more information about Long-Term Care Insurance.

Group Term Life Insurance	
See attached Voluntary Life/Accidental Death & Dismemberment Enrollment Form for additional Plan information and to enroll.	

Tax-Saver Flexible Benefit Plans (must complete separate enrollment form)	
Type of Coverage	Monthly Premium
Healthcare Spending Account	See Your Employee Benefits Book for Admin Fees
Dependent Care Spending Account	

I have been given the opportunity to enroll in the above Voluntary Benefits within thirty (30) days from my date of hire and understand that if I decline now I will be subject to the Late Applicant rules specific to each benefit. I have been given a copy of Your Employee Benefits Book in which the rules are described in detail.

I hereby apply for the coverages I have indicated above and I authorize my employer to make the appropriate deductions, if any, from my wages to pay for my share of the cost. I understand that in the event of any discrepancy between any of these documents and the policy, the terms of the policy apply.

Employee Signature: _____ Date: _____