



**INSURANCE AGREEMENT FOR COOPERATIVE EXTENSION
EMPLOYEES ON PERSONALLY OWNED VEHICLES**

I, the undersigned, understand that it is the policy of the Louisiana Cooperative Extension Service that all Extension Personnel who travel in personally owned vehicles while performing their official duties will carry insurance on these vehicles in the amount of at least \$10,000 for bodily injury to any one person; \$20,000 bodily injury liability as a result of any one accident; and \$10,000 property damage liability.

As long as I am an employee of the Louisiana Cooperative Extension Service, I agree to keep in force at all times, at least the amount of insurance indicated above on all personally owned vehicles that I use while performing my official duties as an Extension employee.

Signature

Date

Benefit Plan Enrollment/Change Form

ENROLLING				DECLINING COVERAGE			CHANGING INFORMATION		
Enrollment for: <input type="checkbox"/> Myself and my dependents (family coverage) <input type="checkbox"/> Myself only (single coverage) because: <input type="checkbox"/> I have no dependents <input type="checkbox"/> My dependents have other insurance <input type="checkbox"/> I don't wish to purchase dependent coverage		Plan Selections: <input type="checkbox"/> Basic Life <input type="checkbox"/> AD&D		Reason: <input type="checkbox"/> I have other insurance <input type="checkbox"/> I don't wish to purchase coverage			<input type="checkbox"/> Updating General Information <input type="checkbox"/> Transferring to a different plan <input type="checkbox"/> Adding a dependent		
General Information (always complete this section)							Life Insurance		
Name Last		First MI		Occupation			If your employer is paying the full cost for this coverage, you are automatically covered under this benefit.		
Street		Daytime Telephone (____) _____		Evening Telephone (____) _____					
City		State Zip Code		Email address			Beneficiary	Relationship	%
County		Date of Birth / /		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Married Date of Marriage ____/____/____			1.		
Social Security Number		Sex <input type="checkbox"/> M <input type="checkbox"/> F					2.		
							3.		
Dependent Information									
Name (Last, First, M.I.)				Date of Birth (MM/DD/YYYY)		Relationship To Employee		Sex	Full-time Student
Spouse								<input type="checkbox"/> M <input type="checkbox"/> F	
Social Security Number									
Child								<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No
Social Security Number									
Child								<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No
Social Security Number									
Child								<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No
Social Security Number									
Child								<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No
Social Security Number									
NOTE: Any person who, with intent to defraud or knowing that he is facilitating a fraud against a claims administrator of payer, submits an application or files a claim containing a false or deceptive statement is guilty of fraud. Such action is considered to be a felony in some states. <i>By my signature below, I acknowledge that I have read and understand the disclosure on the back of this application. I authorize the required payroll deduction for contributory benefits. I also represent that all information shown on this application is correct.</i>									
Employee Signature								Date (MM/DD/YYYY)	