Board of Supervisors of Louisiana State University and Agricultural and Mechanical College
Voluntary Life/Accidental Death & Dismemberment Enrollment Form

EMPLOYEE INFORMATION

Employee Name	Date of Birth	Sex	SSN
		❑ Male ❑ Female	
Employee Address	**Date of Hire**	**Campus**	
Spouse's Name	**Spouse's Date of Birth**	**Employee's Base Annual Earnings / # of Hours Worked**	
		$ /_______________	

LIFE COVERAGE SELECTION

Employee Life: Guaranteed Issue up to the lesser of $500,000 or 5 times Basic Annual Earnings in increments of $10,000 with a maximum of $1,000,000. Amounts over $500,000 will be subject to Evidence of Insurability (E of I). Once covered, an employee may increase coverage by one time his/her base annual earnings per year up to the applicable limits during Annual Enrollment, Guaranteed Issue. Late entrants may elect coverage in increments of $10,000, with evidence of insurability and be approved by The Hartford before coverage becomes effective.

Spouse Life: Up to the lesser of 50% of Employee coverage or $100,000 in $5,000 increments, with a Guaranteed Issue Limit of $100,000. Additional coverage up to 50% of the employee's life coverage is available in $5,000 increments to a maximum of $250,000; subject to E of I.

Child(ren): Children from live birth to 6 months of age are covered for $1,000, if selected. Check a coverage option below.

Age	Employee Rate / $10,000	Spouse Rate / $5,000
<25	$0.55	$0.28
25-29	$0.65	$0.33
30-34	$0.75	$0.38
35-39	$0.95	$0.48
40-44	$1.19	$0.60
45-49	$1.68	$0.84
50-54	$2.85	$1.43
55-59	$4.35	$2.18
60-64	$6.60	$3.30
65-69	$10.90	$5.45
70-74	$20.50	$10.25
75-79	$34.30	$17.15
80-84	$60.90	$30.45
85+	$115.10	$57.55

Coverage Selection		Premium Calculation					
Life	**Coverage**	÷	**# Units**	**X**	**Rate**	**=**	**Mo. Amount**
Employee	$	÷	$10,000	X		=	
Spouse	$	÷	$5,000	X		=	
Child(ren)	❑ $5,000 for each eligible dependent child **$0.75/mo.** ❑ $10,000 for each eligible dependent child **$1.49/mo.** ❑ $20,000 for each eligible dependent child **$2.98/mo.**						
AD&D Coverage: Amount equal to life insurance coverage							
Employee	$	÷	$10,000	X	$0.31	=	
Spouse	$	÷	$5,000	X	$0.16	=	

SPOUSE INFORMATION *Complete spouse information if you have elected life insurance coverage for your spouse.*

Name of Spouse(last name, first, mi)	DOB	SSN

DEPENDENT INFORMATION *Complete dependent information if you have elected life insurance coverage for your dependent(s).*

Name of Dependent(last name, first, mi)	DOB	SSN

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EF (395208)

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EMPLOYEE BENEFICIARY INFORMATION *Designate your beneficiary(ies) below*

Primary Employee Beneficiary(ies)

Name of Beneficiary (last name, first, mi)	Relationship	Benefit %

Contingent Employee Beneficiary(ies)

Name of Beneficiary (last name, first, mi)	Relationship	Benefit %

SPOUSE BENEFICIARY INFORMATION *Your spouse may designate separate beneficiary(ies) below*

Primary Spouse Beneficiary(ies)

Name of Beneficiary (last name, first, mi)	Relationship	Benefit %
Signature of Spouse: ____________________________Date:____________		

Contingent Spouse Beneficiary(ies)

Name of Beneficiary (last name, first, mi)	Relationship	Benefit %
Signature of Spouse: ____________________________Date:______________		

READ THIS INFORMATION CAREFULLY AND THEN SIGN, COMPLETE SS# AND DATE BELOW ▼

- I authorized my employer to deduct from my wages the premium, if any, for the elected coverage.
- To the best of my knowledge and belief, the information I have provided on this form is correct.
- **I understand that any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**
- I understand my coverage begins on the effective date assigned by The Hartford Life, provided I am actively at work.
- I also understand that evidence of insurability may be required for coverage to become effective.
- I understand that my premium may change if my age category changes within the benefits plan year.

Employee's Signature	Date Signed

For office use	
Pay type	
Monthly deduct	
Effective date	

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