

LSU ALWAYS VISION INSURANCE ENROLLMENT/CHANGE

(Payroll Deduction Authorization)

_____ Change
 _____ Termination

<p><u>Always Vision Plan</u> _____ Employee + Spouse _____ Employee + Children _____ Family 12 month premium _____</p>

Last Name	First	Middle	_____/_____/_____ Birth Date	____-____-____ Social Security No.
Residence Address			_____ Male _____ Female	_____/_____/_____ Marriage Date
City	State	Zip Code	_____ Single _____ Married	_____ No. of Elig. Dependents
(____) _____ Home Phone	(____) _____ Work Phone	_____ Department	_____/_____/_____ Date Hired	

List all dependents to be participants in the plan:

<u>Last Name</u>	<u>First</u>	<u>Relationship</u>	<u>Date of Birth</u>	M = Male A = Add F = Female D = Delete (Circle)			
_____	_____	_____	_____/_____/_____ _____	M	F	A	D
_____	_____	_____	_____/_____/_____ _____	M	F	A	D
_____	_____	_____	_____/_____/_____ _____	M	F	A	D
_____	_____	_____	_____/_____/_____ _____	M	F	A	D
_____	_____	_____	_____/_____/_____ _____	M	F	A	D
_____	_____	_____	_____/_____/_____ _____	M	F	A	D
_____	_____	_____	_____/_____/_____ _____	M	F	A	D

_____ Change due to:	_____ Marriage	_____/_____/_____ _____	_____ Death	_____/_____/_____ _____
	_____ Divorce	_____/_____/_____ _____	_____ Not Elig	_____/_____/_____ _____
	_____ Birth	_____/_____/_____ _____	_____ Other	_____/_____/_____ _____

I hereby authorize you to deduct _____ Cancel my coverage
 from my pay for the above insurance _____
 coverage (if any required). _____ Term Date

 Employee Signature _____ Date

Office Use Only	
Coverage	_____
eff.	_____/_____/_____ _____
Change	_____
eff.	_____/_____/_____ _____
Total prem.\$	_____
HRM Rep.	_____