



LSU DENTAL INSURANCE CHANGE FORM

Check desired change in existing coverage

D1 _Denta-Care I _Employee _Empl. + 1 _Family _Family (6 or More dep.)	D2 _Denta-Care II _Employee _Empl. + 1 _Family _Family (6 or More dep.)	D3 _Denta-Care I _Employee _Empl. + 1 _Family _Family (6 or More dep.)	D4 _LA Dental _Employee _Empl. + 1 _Family (no limit)	D5 _Bene-Dent _Employee _Empl. + 1 _Family (no limit)	D6 _Paid Dental _Employee _Empl. & Spouse _Empl. & Children _Empl. & Family
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Last Name _____ First _____ Middle _____ Birthdate _____ / ____ / ____ Social Security Number _____
 _____ Male _____ Female _____ / ____ / ____
 Residence Address _____ Marriage Date _____
 _____ Single _____ Married _____ No. of Eligible Dependents _____
 City _____ State _____ Zip Code _____
 () _____ () _____ Department _____ / ____ / ____
 Home Phone _____ Work Phone _____ Date Hired _____

List all dependents to be participants in the plan:

Last Name	First	Relationship	Date of Birth	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 _____ Marriage _____ Date _____ / ____ / ____
 _____ Divorce _____ / ____ / ____
 _____ Birth _____ / ____ / ____
 _____ Death _____ Date _____ / ____ / ____
 _____ Not elig. _____ / ____ / ____
 _____ Other _____ / ____ / ____

I hereby authorize you to deduct from my pay for the above insurance coverage (if any required). _____ Employee Signature	_____ Cancel my coverage _____ / ____ / ____ Term Date	Office Use Only Coverage effective _____ / ____ / ____ Change effective _____ / ____ / ____ Total premium \$ _____ LSU Rep _____
	_____ / ____ / ____	
	_____ / ____ / ____	
	_____ / ____ / ____	