



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				
			<u> </u> / <u> </u> / <u> </u>	(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 _____ Date / /
 _____ Birth _____ Date / /
 _____ Death _____ Date / /
 _____ Not elig. _____ Date / /
 _____ Other _____ Date / /

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