



LSU SYSTEM VOLUNTARY BENEFITS ENROLLMENT/CHANGE FORM

Check the box for the Plan you would like to enroll in or make changes to. All Employee and applicable Dependent sections must be completely filled out in the event you are making changes. Descriptions of each Plan can be found in your Benefits Book. Contact your local HR/Benefit Staff for additional information.

FOR OFFICE USE ONLY (All fields are REQUIRED)

Effective Date of Change: _____
 HR/Payroll Rep: _____
 Pay Type: _____
 Campus/Hospital: _____
 Date Event Occurred: _____

TYPE OF CHANGE (REQUIRED)

Birth/Adoption	New Hire	Death
Marriage	Emp Status	Divorce
Retirement	Termination	Add/Delete Dependent
Cancellation	Demographic Change	Other _____

Last Name		First Name		MI	Date of Birth		Social Security #		Date of Hire
Mailing Address					City		State	Zip Code	
Gender	Home Telephone #		Work Telephone #		Email Address		Marital Status	Marital Date	

<input type="checkbox"/> Add <input type="checkbox"/> Delete	SPOUSE	Last Name	First Name	MI	SSN	Gender	DOB	
<input type="checkbox"/> Add <input type="checkbox"/> Delete	DEPENDENT	Last Name	First Name	MI	SSN	Gender	DOB	
<input type="checkbox"/> Add <input type="checkbox"/> Delete	DEPENDENT	Last Name	First Name	MI	SSN	Gender	DOB	
<input type="checkbox"/> Add <input type="checkbox"/> Delete	DEPENDENT	Last Name	First Name	MI	SSN	Gender	DOB	
Address if different from employee		Mailing Address			City		State	Zip Code

*****LIST ADDITIONAL DEPENDENTS ON THE BACK (or page 2) OF THIS FORM*****

DENTAL	I would like to enroll in the following plan and level of coverage:				
	Level of Coverage	Employee Only	Employee & Spouse	Employee & Child(ren)	Family
	Enhanced Plan (12 Months)	<input type="checkbox"/> \$28.36	<input type="checkbox"/> \$55.48	<input type="checkbox"/> \$67.44	<input type="checkbox"/> \$94.55
	Basic Plan (12 Months)	<input type="checkbox"/> \$17.88	<input type="checkbox"/> \$33.60	<input type="checkbox"/> \$46.45	<input type="checkbox"/> \$62.16
<input type="checkbox"/> I would like to cancel my dental coverage. <input type="checkbox"/> I do not wish to enroll.					

VISION	I would like to enroll in the following plan and level of coverage:					Check this box if you are enrolled in the LSU First Health Plan. <input type="checkbox"/>
	Level of Coverage	Employee Only	Employee & Spouse	Employee & Child(ren)	Family	
	Premium (12 Months)	<input type="checkbox"/> \$7.66	<input type="checkbox"/> \$12.90	<input type="checkbox"/> \$13.18	<input type="checkbox"/> \$21.24	
<input type="checkbox"/> I would like to cancel my vision coverage. <input type="checkbox"/> I do not wish to enroll.						

ACCIDENTAL DEATH & DISMEMBERMENT	I would like to enroll in the following plan:		AD&D Beneficiary Designation		
	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Family	Primary Name(s)	Relationship	% of Benefit
	Coverage Amount \$ _____		1.		
	<input type="checkbox"/> I would like to cancel my AD&D. <input type="checkbox"/> I do not wish to enroll.		2.		
		Contingent Name(s)			
		1.			
		2.			

LONG TERM DISABILITY	<input type="checkbox"/> Yes, I would like to enroll in Long Term Disability. \$ _____ Monthly Salary x \$0.00553 = \$ _____ Monthly Premium
	<input type="checkbox"/> I would like to cancel my Long Term Disability coverage. <input type="checkbox"/> I do not wish to enroll.

PREMIUMS ONLY PLAN	<input type="checkbox"/> Yes, I elect to PARTICIPATE in the Premiums Only Plan. I understand that eligible insurance premiums will be deducted pre-tax, will remain in effect, and cannot be cancelled or changed during the plan year unless the cancellation or change is within the guidelines of the LSU System Flexible Benefits Plan.
	<input type="checkbox"/> I would like to cancel my participation in the Premiums Only Plan. <input type="checkbox"/> I do not wish to enroll.

I authorize my employer to deduct from my wages the premiums, 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 persons who knowingly present a false or fraudulent claim for payment of loss or benefit or knowingly present false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Employee Signature: _____ Date: _____



LSU SYSTEM VOLUNTARY BENEFITS ENROLLMENT/CHANGE FORM

<input type="checkbox"/> Add <input type="checkbox"/> Delete	DEPENDENT	Last Name	First Name	MI	SSN	Gender	DOB
<input type="checkbox"/> Add <input type="checkbox"/> Delete	DEPENDENT	Last Name	First Name	MI	SSN	Gender	DOB
<input type="checkbox"/> Add <input type="checkbox"/> Delete	DEPENDENT	Last Name	First Name	MI	SSN	Gender	DOB
<input type="checkbox"/> Add <input type="checkbox"/> Delete	DEPENDENT	Last Name	First Name	MI	SSN	Gender	DOB
<input type="checkbox"/> Add <input type="checkbox"/> Delete	DEPENDENT	Last Name	First Name	MI	SSN	Gender	DOB
	Address if different from employee	Mailing Address			City	State	Zip Code