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

		Last Name	First Name	MI	SSN	Gender	DOB
☐ Add ☐ Delete	**SPOUSE**						
☐ Add ☐ Delete	**DEPENDENT**						
☐ Add ☐ Delete	**DEPENDENT**						
☐ Add ☐ Delete	**DEPENDENT**						

	Address if different from employee	Mailing Address	City	State	Zip Code

*****LIST ADDITIONAL DEPENDENTS ON THE BACK 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)	☐ $26.26	☐ $51.37	☐ $62.44	☐ $87.55
Basic Plan (12 Months)	☐ $16.56	☐ $31.11	☐ $43.01	☐ $57.56

☐ **I would like to cancel my dental coverage.** ☐ **I do not wish to enroll.**

VISION

I would like to enroll in the following plan and level of coverage:

Level of Coverage	Employee Only	Employee & Spouse	Employee & Child(ren)	Family
Premium (12 Months)	☐ $7.66	☐ $12.90	☐ $13.18	☐ $21.24

Check this box if you are enrolled in the LSU First Health Plan. ☐

☐ **I would like to cancel my vision coverage.** ☐ **I do not wish to enroll.**

ACCIDENTAL DEATH & DISMEMBERMENT

I would like to enroll in the following plan:

☐ Employee Only

☐ Family

Coverage Amount $_____

☐ I would like to cancel my AD&D.
☐ I do not wish to enroll.

AD&D Beneficiary Designation

Primary Name(s)	**Relationship**	**% of Benefit**
1.		
2.		

Contingent Name(s)

1.

2.

LONG TERM DISABILITY

☐ Yes, I would like to enroll in Long Term Disability. $_____ Monthly Salary x $0.00553 = $_____ Monthly Premium
☐ I would like to cancel my Long Term Disability coverage. ☐ I do not wish to enroll.

PREMIUMS ONLY PLAN

☐ 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.
☐ I would like to cancel my participation in the Premiums Only Plan. ☐ 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

☐ Add ☐ Delete	**DEPENDENT**	Last Name	First Name	MI	SSN	Gender	DOB
☐ Add ☐ Delete	**DEPENDENT**	Last Name	First Name	MI	SSN	Gender	DOB
☐ Add ☐ Delete	**DEPENDENT**	Last Name	First Name	MI	SSN	Gender	DOB
☐ Add ☐ Delete	**DEPENDENT**	Last Name	First Name	MI	SSN	Gender	DOB
☐ Add ☐ Delete	**DEPENDENT**	Last Name	First Name	MI	SSN	Gender	DOB
	Address if different from employee	Mailing Address		City		State	Zip Code