LOUISIANA STATE UNIVERSITY

VOLUNTARY BENEFIT ENROLLMENT/CHANGE FORM

Check the box for the benefit(s) 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 on your HR's website or in the 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: _____
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	Social Security #	
Mailing Address	City	State	Zip Code	
Gender	Home Phone	Work Phone	Email Address	
Birth date	Hire date	Marital date	Retirement date	

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

DENTAL

Level of Coverage	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Basic Plan	☐ $20.72	☐ $38.92	☐ $53.78	☐ $71.98
Enhanced Plan	☐ $38.06	☐ $74.50	☐ $90.56	☐ $126.94

☐ **I am enrolling in dental coverage** ☐ **I am cancelling dental coverage** ☐ **I do not wish to enroll**

VISION

Level of Coverage	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Premium	☐ $7.40	☐ $12.46	☐ $12.72	☐ $20.50

☐ **I am enrolling in vision coverage** ☐ **I am cancelling vision coverage** ☐ **I do not wish to enroll**

IDENTITY THEFT

Level of Coverage	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
UltraSecure	☐ $9.96	☐ $19.92	☐ $9.96	☐ $19.92
UltraSecure+Credit	☐ $16.96	☐ $33.92	☐ $16.96	☐ $33.92

☐ **I am enrolling in identity theft protection** ☐ **I am cancelling identity theft protection** ☐ **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: _____