

CHANGE FORM FOR CURRENT DENTAL PLAN MEMBERS

Use this form to make the following changes:

- To change name or address
- Add a dependent to your plan (spouse and/or children) – Effective date of coverage will be July 1
- Remove a dependent from your plan (spouse and/or children) – Effective date of cancellation will be June 30, unless the dependent ceases to be eligible on an earlier date

Return this form to the Human Resources Management Benefits Office:

LSU Health Sciences Center
Human Resources Management Department
433 Bolivar Street, Ste 608
New Orleans, LA 70112

If you have questions or need assistance, contact the Benefits Office:

Tasha Treuil, ttreui@lsuhsc.edu (504) 568-7780
Louis Bundy, lbundy@lsuhsc.edu (504) 568-4226
Marie Cole, mcole@lsuhsc.edu (504) 568-7378
Ginger Blanchard, gblanc1@lsuhsc.edu (504) 568-8740

If necessary, you may fax your document to the Benefits Office. Since faxes are often of poor quality, please follow-up by mailing the original so we will have a legible copy.

LSUHSC Benefits Office
Fax: (504) 568-2212

AMERITAS DENTAL CHANGE FORM

Check desired change in coverage:		Campus / Hospital		
Prior: <input type="checkbox"/> Emp Only <input type="checkbox"/> Emp+Sp <input type="checkbox"/> Emp+Ch <input type="checkbox"/> Family	New: <input type="checkbox"/> Emp Only <input type="checkbox"/> Emp+Sp <input type="checkbox"/> Emp+Ch <input type="checkbox"/> Family	<input type="checkbox"/> LSU System <input type="checkbox"/> LSU A&M <input type="checkbox"/> LSU-Alex <input type="checkbox"/> LSU-Eunice <input type="checkbox"/> Law Center <input type="checkbox"/> Pennington <input type="checkbox"/> Ag. Center	<input type="checkbox"/> LSU-Shrev <input type="checkbox"/> UNO <input type="checkbox"/> HSC-Shrev <input checked="" type="checkbox"/> HSC-New Orl <input type="checkbox"/> HCSD Hqtrs <input type="checkbox"/> Med Ctr of LA <input type="checkbox"/> Conway	<input type="checkbox"/> EK Long MC <input type="checkbox"/> HP Long MC <input type="checkbox"/> Lallie Kemp MC <input type="checkbox"/> Moss Reg MC <input type="checkbox"/> University MC <input type="checkbox"/> Bogalusa MC

Last name _____ First _____ Middle _____ Birth date ____/____/____ Social Security No. _____
 Home Street Address _____ Male _____ Female _____ Marriage Date ____/____/____
 City _____ State _____ Zip Code _____ Single _____ Married _____ No. of Eligible Dependents _____
 Home Phone (____) _____ Work Phone (____) _____ Department _____ Date of Hire ____/____/____

List all Dependents participating in the plan:

<u>Last Name</u>	<u>First</u>	<u>Relationship</u>	<u>Date of Birth</u>	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

Dependent(s) home address if different from employee:

Name _____ Street _____ City _____ State _____ Zip Code _____

Change due to:

<input type="checkbox"/> Marriage _____/____/____ <input type="checkbox"/> Divorce _____/____/____ <input type="checkbox"/> Birth _____/____/____	<input type="checkbox"/> Death _____/____/____ <input type="checkbox"/> Not elig. _____/____/____ <input type="checkbox"/> Other _____/____/____
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I hereby authorize you to deduct from my pay for the above insurance coverage (if any required) _____ <input type="checkbox"/> Cancel my coverage _____/____/____ Term Date _____/____/____ Employee Signature _____ Date _____	Office Use Only Coverage eff. ____/____/____ Change eff. ____/____/____ Total Prem. \$ _____ HR/Payroll Rep _____
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