

CHANGE FORM FOR CURRENT VISION 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

STARMOUNT LIFE INSURANCE COMPANY CHANGE REQUEST

COMPANY NAME: LSU SYSTEM

ACCOUNT NUMBER: CAMPUS D-10

EMPLOYEE NAME: _____

SOCIAL SECURITY #: _____

TYPE OF CHANGE: (Please list below)

SPECIAL EVENTS: (Please provide actual date and dependent name below)

1. Add New Employee (Attach Enrollment Form)
2. Name Change
3. Address Change
4. Cancel Dependent(s)
11. Other - Add Dependent Annual Enrollment

COMPLETE FOR ELIGIBLE EMPLOYEE OR DEPENDENT(S) CHANGING

SPECIAL EVENT OR TYPE OF CHANGE	#	EFFECTIVE DATE	LAST NAME	FIRST NAME	EMPLOYEES SS #	BIRTHDAY MO/DAY/YR	SEX	SALARY/ADDRESS CHANGE	COVERAGES AFFECTED

(All necessary information must be included to avoid processing delays)

COMMENTS:

EMPLOYER'S (OR REPRESENTATIVE) SIGNATURE _____

EMPLOYEE'S SIGNATURE _____

PHONE NUMBER _____

DATE _____