



Financial Protection

LOUISIANA STATE UNIVERSITY

ENROLLMENT/CHANGE FORM

FOR OFFICE USE ONLY

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

Check the box for the Financial Protection 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. Contact your local HR/Benefit Staff for additional information.

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	Annual Salary		

<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
<input type="checkbox"/> Add <input type="checkbox"/> Delete	DEPENDENT	Last Name	First Name	MI	SSN	Gender	DOB

TERM LIFE	Employee	<input type="checkbox"/> \$_____ Total coverage (must be in \$10,000 increments)				
	Spouse	<input type="checkbox"/> \$_____ Total coverage (must be in \$5,000 increments, not to exceed 50% of employee coverage)				
	Child(ren)	<input type="checkbox"/> \$5,000 (\$0.35/month)	<input type="checkbox"/> \$10,000 (\$0.70/month)	<input type="checkbox"/> \$15,000 (\$1.05/month)	<input type="checkbox"/> \$20,000 (\$1.40/month)	
	<input type="checkbox"/> I am enrolling in Life coverage		<input type="checkbox"/> I am cancelling Life coverage		Office Use Only SUBTOTAL:	

CRITICAL ILLNESS		Employee Only	Spouse 50% of EE/must be same option	Child(ren) 25% of Employee/must be same option
	Low Option	<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$2,500
	Mid Option	<input type="checkbox"/> \$20,000	<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$5,000
	High Option	<input type="checkbox"/> \$30,000	<input type="checkbox"/> \$15,000	<input type="checkbox"/> \$7,500
<input type="checkbox"/> I am enrolling in CI coverage		<input type="checkbox"/> I am cancelling CI coverage		Office Use Only SUBTOTAL:

ACCIDENT	Level of Coverage	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
	Premium	<input type="checkbox"/> \$9.15	<input type="checkbox"/> \$13.60	<input type="checkbox"/> \$12.36	<input type="checkbox"/> \$16.81
	<input type="checkbox"/> I am enrolling in Accident coverage		<input type="checkbox"/> I am cancelling Accident coverage		Office Use Only SUBTOTAL:

LTD	Long Term Disability Calculation—\$_____ Monthly Salary x rate \$0.00362= \$_____ Monthly Premium	
	<input type="checkbox"/> I am enrolling in LTD coverage	<input type="checkbox"/> I am cancelling LTD coverage
Office Use Only SUBTOTAL:		

AD&D	<input type="checkbox"/> Employee	<input type="checkbox"/> \$27,500 (\$0.52/\$0.77)	<input type="checkbox"/> \$55,000 (\$1.05/\$1.54)	<input type="checkbox"/> \$82,500 (\$1.57/\$2.31)	<input type="checkbox"/> \$110,000 (\$2.09/\$3.08)
	<input type="checkbox"/> Family	<input type="checkbox"/> \$165,000 (\$3.14/\$4.62)	<input type="checkbox"/> \$220,000 (\$4.18/\$6.16)	<input type="checkbox"/> \$275,000 (\$5.23/\$7.70)	<input type="checkbox"/> \$300,000 (\$5.70/\$8.40)
	<input type="checkbox"/> I am enrolling in AD&D coverage		<input type="checkbox"/> I am cancelling AD&D coverage		Office Use Only SUBTOTAL:



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Voluntary Life		
Age Bands	Rates per \$5,000	Rates per \$10,000
24 and under	\$0.16	\$0.32
25-29	\$0.20	\$0.39
30-34	\$0.23	\$0.45
35-39	\$0.29	\$0.57
40-44	\$0.36	\$0.71
45-49	\$0.50	\$1.00
50-54	\$0.85	\$1.70
55-59	\$1.30	\$2.60
60-64	\$1.97	\$3.94
65-69	\$3.25	\$6.50
70-74	\$6.12	\$12.23
75-79	\$10.23	\$20.46
80-84	\$18.17	\$36.33
Employee rates based on Employee age Spouse rates based on Spouse age		

Critical Illness		
Age Bands	Rates per \$5,000	Rates per \$10,000
24 and under	\$1.65	\$3.30
25-29	\$2.60	\$5.20
30-34	\$3.00	\$6.00
35-39	\$3.75	\$7.50
40-44	\$5.00	\$10.00
45-49	\$7.50	\$15.00
50-54	\$9.75	\$19.50
55-59	\$13.75	\$27.50
60-64	\$19.10	\$38.20
65-69	\$27.30	\$54.60
70-74	\$39.70	\$79.40
75-79	\$51.35	\$102.70
80-84	\$51.35	\$102.70
Employee rates based on Employee age Spouse rates based on Employee age		

Last Name		First Name		MI
Mailing Address				
City		State	Zip	
SSN		Birth Date		

VOLUNTARY LIFE	Primary Beneficiary Name(s)	Relationship	% of Benefit
	Contingent Beneficiary Name(s)	Relationship	% of Benefit

CRITICAL ILLNESS	Primary Beneficiary Name(s)	Relationship	% of Benefit
	Contingent Beneficiary Name(s)	Relationship	% of Benefit

ACCIDENT	Primary Beneficiary Name(s)	Relationship	% of Benefit
	Contingent Beneficiary Name(s)	Relationship	% of Benefit

AD&D	Primary Beneficiary Name(s)	Relationship	% of Benefit
	Contingent Beneficiary Name(s)	Relationship	% of Benefit

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: _____