LSU
LOUISIANA STATE UNIVERSITY

Financial Protection

ENROLLMENT/CHANGE FORM

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.

FOR OFFICE USE ONLY

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**	**Annual Salary**

☐ Add ☐ Delete	**SPOUSE**	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

TERM LIFE

Employee	☐ $_____ **Total coverage** (must be in $10,000 increments)
Spouse	☐ $_____ **Total coverage** (must be in $5,000 increments, not to exceed 50% of employee coverage)
Child(ren)	☐ $5,000 ($0.35/month) ☐ $10,000 ($0.70/month) ☐ $15,000 ($1.05/month) ☐ $20,000 ($1.40/month)

☐ **I am enrolling in Life coverage** ☐ **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	☐ $10,000	☐ $5,000	☐ $2,500
Mid Option	☐ $20,000	☐ $10,000	☐ $5,000
High Option	☐ $30,000	☐ $15,000	☐ $7,500

☐ **I am enrolling in CI coverage** ☐ **I am cancelling CI coverage** **Office Use Only SUBTOTAL:**

ACCIDENT

Level of Coverage	**Employee Only**	**Employee + Spouse**	**Employee + Child(ren)**	**Family**
Premium	☐ $9.15	☐ $13.60	☐ $12.36	☐ $16.81

☐ **I am enrolling in Accident coverage** ☐ **I am cancelling Accident coverage** **Office Use Only SUBTOTAL:**

LTD

Long Term Disability Calculation—$_____ Monthly Salary x rate $0.00362= $_____ Monthly Premium

☐ **I am enrolling in LTD coverage** ☐ **I am cancelling LTD coverage** **Office Use Only SUBTOTAL:**

AD&D

☐ Employee
☐ Family

☐ $27,500 ($0.52/$0.77) ☐ $55,000 ($1.05/$1.54) ☐ $82,500 ($1.57/$2.31) ☐ $110,000 ($2.09/$3.08)
☐ $165,000 ($3.14/$4.62) ☐ $220,000 ($4.18/$6.16) ☐ $275,000 ($5.23/$7.70) ☐ $300,000 ($5.70/$8.40)

☐ **I am enrolling in AD&D coverage** ☐ **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: _____