



**LSU System Voluntary Benefits Change/Cancellation Form**

<b>Campus/ Hospital</b>	<b>Effective Date of Change:</b>	<b>Campus Code:</b>
<input type="checkbox"/> LSU System <input type="checkbox"/> LSU –Shrev <input type="checkbox"/> EK Long MC <input type="checkbox"/> LSU A&M <input type="checkbox"/> UNO <input type="checkbox"/> HP Long MC <input type="checkbox"/> LSU – Alex <input type="checkbox"/> HSC- Shrev <input type="checkbox"/> Lallie Kemp MC <input type="checkbox"/> LSU-Eunice <input type="checkbox"/> HSC-NO <input type="checkbox"/> WO Moss Reg MC <input type="checkbox"/> Law Center <input type="checkbox"/> HCSD HQ <input type="checkbox"/> University MC <input type="checkbox"/> Pennington <input type="checkbox"/> Med Ctr of LA <input type="checkbox"/> Bogalusa MC <input type="checkbox"/> Ag Center <input type="checkbox"/> EA Conway MC <input type="checkbox"/> LJ Chabert MC	<input style="width:100%;" type="text"/> <input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/> <input style="width:100%;" type="text"/>
	<b>Type of Change:</b>	
	<input type="checkbox"/> Address/Phone # <input type="checkbox"/> Cancel Coverage for Employee <input type="checkbox"/> Cancel Coverage for Spouse/Dependent <input type="checkbox"/> Level Of Coverage (see Level of Coverage box) <input type="checkbox"/> Name <input type="checkbox"/> Other _____	

<b>Benefit to be Changed:</b>	<b>Reason for Change: Exact Date of Event</b>	<b>NOTES:</b>
<input type="checkbox"/> AD&D	Birth/Adoption: ___/___/___	<div style="border: 1px solid black; height: 150px;"></div>
<input type="checkbox"/> Dental (Basic Plan)	Marriage: ___/___/___	
<input type="checkbox"/> Dental (Enhanced Plan)	Divorce: ___/___/___	
<input type="checkbox"/> LSU Life Insurance	Death: ___/___/___	
<input type="checkbox"/> Long Term Disability	Loss of Eligibility (Employee): ___/___/___	
<input type="checkbox"/> Long Term Care	Loss of Eligibility(Spouse/Dep): ___/___/___	
<input type="checkbox"/> Vision	Retirement: ___/___/___	
<input type="checkbox"/> Other	Termination (Voluntary): ___/___/___	
	Termination (Involuntary): ___/___/___	
	Other: _____	

**Demographic Information:**

Current Last Name	Current First Name	MI	___/___/___ Birth date	EE ID or SSN
New Last Name	New First Name	MI		
New Home Street Address	New Home City	New State	New Zip Code	
New Home Telephone #	New Work Telephone #			

<b>Check desired change in Level of Coverage:</b>		<b>List Dependents being removed from or added to the Plan:</b>		
<b>Prior Level:</b>	<b>New Level:</b>	<b>Last Name</b>	<b>First Name</b>	<b>Relationship</b>
<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee Only	_____	_____	_____
<input type="checkbox"/> Emp + Spouse	<input type="checkbox"/> Emp + Spouse	_____	_____	_____
<input type="checkbox"/> Emp + Child(ren)	<input type="checkbox"/> Emp + Child(ren)	_____	_____	_____
<input type="checkbox"/> Family	<input type="checkbox"/> Family	_____	_____	_____

I hereby authorize my Employer to: <input type="checkbox"/> make the appropriate change(s) as indicated above.  _____ Employee Signature <span style="float:right;">Date</span>	<b>For Office Use Only</b> Coverage Effective: _____ Change Effective: _____ Total Premium: \$ _____ HR/Payroll Rep Signature: _____
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NOTE: This form is for Voluntary Benefits ONLY. All Changes/Terminations for LSU First Health Plan Members must be made on the GB-01 and entered into E-enrollment and Ceridian (if applicable).