

# AMERITAS DENTAL CHANGE FORM

<b>Check desired change in coverage:</b>  <b>Prior:</b> <input type="checkbox"/> Emp Only <input type="checkbox"/> Emp+Sp <input type="checkbox"/> Emp+Ch <input type="checkbox"/> Family  <b>New:</b> <input type="checkbox"/> Emp Only <input type="checkbox"/> Emp+Sp <input type="checkbox"/> Emp+Ch <input type="checkbox"/> Family	<b>Campus / Hospital</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-New Orl <input type="checkbox"/> Moss Reg MC <input type="checkbox"/> Law Center <input type="checkbox"/> HCSD Hqtrs <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"/> Conway
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Last name	First	Middle	/ /	Social Security No.
			Male <input type="checkbox"/> Female <input type="checkbox"/>	/ /
Home Street Address				Marriage Date
City	State	Zip Code	Single <input type="checkbox"/> Married <input type="checkbox"/>	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
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Change due to:	Marriage	Date	/ /	Death	Date	/ /
	Divorce	Date	/ /	Not elig.	Date	/ /
	Birth	Date	/ /	Other	Date	/ /

I hereby authorize you to deduct from my pay for the above insurance coverage (if any required)	<b>Office Use Only</b> Coverage eff. ___/___/___ Change eff. ___/___/___ Total Prem. \$ _____ HR/Payroll Rep _____
<input type="checkbox"/> Cancel my coverage ___/___/___ Term Date ___/___/___	
Employee Signature	Date