LIFE/LTC INSURANCE ENROLLMENT/CHANGE

(Payroll Deduction Authorization)

Human Resource Mgmt
304 Thomas Boyd

___ New enrollment ___ Change ___ Cancel & Term. (check desired plan and coverage)

___ UNUM Life	___ Amer Heritage Un	___ New York Life	___ Realistar/Horizon	___ Provident Univ	___ UNUM Long Term Care
___ Employee ___ Empl AD&D ___ Spouse ___ Spouse AD&D ___ Children ___ Children AD&D Ded Code 014	___ Employee ___ Employee plus one ___ Family 12 mo rate prem ___ Ded Code 006	___ Employee ___ Employee plus one ___ Family 12 mo rate prem ___ Ded Code 007	___ Employee ___ Spouse ___ Children 12 mo rate prem ___ Ded Code 110	___ Employee ___ Spouse ___ Children 12 mo rate prem ___ Ded Code 112	___ Employee ___ Employee & Spouse ___ Spouse Ded Code 124

Last Name ___ First ___ Middle ___ Birthdate ___/___/___ Social Security No. ___-___-___

Residence Address ___ ___ Male ___ Female Marriage Date ___/___/___

City ___ State ___ Zip Code ___ ___ Single ___ Married ___ No. of Elig. Dependents

( ) ___ Home Phone ( ) ___ Work ___ Department ___ Date Hired ___/___/___

List all dependents to be participants in the plan:

M-Male A-Add
F-Female D-Delete
(Circle)

Last Name	First	Relationship	Date of Birth	
			___/___/___	M F A D
			___/___/___	M F A D
			___/___/___	M F A D
			___/___/___	M F A D
			___/___/___	M F A D
			___/___/___	M F A D
			___/___/___	M F A D

___ Change, due to:		Date		Date		Date
	___ Marriage	___/___/___	___ Death	___/___/___	___ Not eligible	___/___/___
	___ Divorce	___/___/___	___ Birth	___/___/___	___ Other	___/___/___

I hereby authorize

___ deductions from my pay for the insurance coverage indicated above (if any required)	___ cancellation of my coverage	Term Date ___/___/___
Employee Signature		Date ___/___/___

For Office Use Only
Coverage effec ___/___/___
Change effec ___/___/___
Total premium $
LSU Rep