ALWAYS VISION ENROLLMENT/CHANGE

(Payroll Deduction Authorization)

Human Resource Mgmt
304 Thomas Boyd

___ New enrollment ___ Change

Vision Service Plan	12 Month Rate
{ } Employee Only	$ 8.30
{ } Employee & Children	14.26
{ } Employee & Spouse	13.96
{ } Employee + Family	22.98

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	(Circle)
			/ /	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

			For Office Use Only
___ deductions from my pay for the insurance coverage indicated above (if any required)	___ cancellation of my coverage	Term Date / /	Coverage effec / / Change effec / /
Employee Signature		Date / /	Total premium $ LSU Rep

C:\PAY\Visenrol.PAY r 06/14/02