

DENTAL CHANGE FORM

CHECK DESIRED CHANGE IN EXISTING COVERAGE

| | | | | | |
|--|--|---|---|---|---|
| <input type="checkbox"/> Denta-Care I <input type="checkbox"/> Employee <input type="checkbox"/> Empl + 1 <input type="checkbox"/> Family <input type="checkbox"/> Family (6 or more dep.) | <input type="checkbox"/> Denta-Care II <input type="checkbox"/> Employee <input type="checkbox"/> Empl. + 1 <input type="checkbox"/> Family <input type="checkbox"/> Family (6 or more dep.) | <input type="checkbox"/> All Dent <input type="checkbox"/> Employee <input type="checkbox"/> Empl. + 1 <input type="checkbox"/> Family <input type="checkbox"/> Family (6 or more dep.) | <input type="checkbox"/> LA Dental <input type="checkbox"/> Employee <input type="checkbox"/> Empl. + 1 <input type="checkbox"/> Family <input type="checkbox"/> (no limit) | <input type="checkbox"/> Bene-Dent <input type="checkbox"/> Employee <input type="checkbox"/> Empl. + 1 <input type="checkbox"/> Family <input type="checkbox"/> (no limit) | <input type="checkbox"/> Paid Dental <input type="checkbox"/> Employee <input type="checkbox"/> Empl+ Spouse <input type="checkbox"/> Empl +Children |
|--|--|---|---|---|---|

_____ / ____ / ____ _____ - ____ - ____
 Last name First Middle Birth date Social Security No.

_____ _____ Male _____ Female _____ / ____ / ____
 Residence Address Marriage Date

_____ _____ _____ _____ Single _____ Married _____ No. of Eligible
 City State Zip Code Dependents

(____) _____ (____) _____ _____ _____ / ____ / ____
 Home Phone Work Phone Department Date Hired

List all Dependents to be participants in the plan:

| Last Name | First | Relationship | Date of Birth |
|-----------|-------|--------------|----------------|
| _____ | _____ | _____ | ____/____/____ |
| _____ | _____ | _____ | ____/____/____ |
| _____ | _____ | _____ | ____/____/____ |
| _____ | _____ | _____ | ____/____/____ |
| _____ | _____ | _____ | ____/____/____ |
| _____ | _____ | _____ | ____/____/____ |
| _____ | _____ | _____ | ____/____/____ |

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 |
| M | F | A | D |
| M | F | A | D |

| | | | | |
|----------------------|----------------|---------------------|-----------------|---------------------|
| _____ Change due to: | _____ Marriage | _____ <u>Date</u> | _____ Death | _____ <u>Date</u> |
| | _____ Divorce | _____ / ____ / ____ | _____ Not elig. | _____ / ____ / ____ |
| | _____ Birth | _____ / ____ / ____ | _____ Other | _____ / ____ / ____ |

I hereby authorize you
 to deduct from my pay
 for the above insurance
 coverage (if any required.)

_____ cancel my coverage
 _____ / ____ / ____ Term Date

_____ / ____ / ____
 Employee Signature Date

| |
|-----------------------------------|
| Office Use Only |
| Coverage eff. _____ / ____ / ____ |
| Change eff. _____ / ____ / ____ |
| Total Prem.\$ _____ |
| LSU Rep _____ |