

INSURANCE / FLEXIBLE BENEFITS ACKNOWLEDGMENT

I acknowledge that I have received the LSU employee benefits packet containing information and enrollment documents and I understand that I have 30 calendar days from my date of hire (or date of first eligibility) to enroll in the following insurance /flexible benefits plans:

- Accidental Death & Dismemberment Insurance
- Dental Insurance
- Long-Term Care Insurance
- Long-Term Disability Insurance
- Medical Insurance
- Term Life Insurances
- Universal Life Insurance
- Vision Insurance
- Tax Saver Flexible Benefits Plan
 - Premiums Only Plan
 - Health Care Spending Account
 - Dependent Care Spending Account

I understand that if I elect to enroll in any of the above plans that I must complete and return the applicable enrollment forms to the Office of Human Resource Management, Benefits Service Center, 304 Thomas Boyd Hall, Baton Rouge, LA 70803, within 30 calendar days of my date of hire (or date of eligibility). I further understand that I am responsible for verifying that the correct premiums are being withheld from my paycheck. (See Benefits Summary booklet for effective dates of coverage.)

I understand that if I fail to enroll during my initial eligibility period, I may apply for medical, life and/or disability insurance any time during the year; however, approval for medical insurance will be subject to a pre-existing condition exclusion and approval for life and disability insurance will be subject to evidence of insurability. If I fail to enroll in dental, vision and/or the flexible benefits plan, I understand that I am eligible to enroll during the annual enrollment period or within 30 days of a corresponding qualified family status change (See the LSU *Your Employee Benefits* booklet for additional enrollment information and effective dates of coverage.)

Signature _____ SSN _____ Date _____

(please print) NAME _____ Address _____ City, State, Zip _____

Human Resources Representative _____ Date _____ 01/06/2003