



LOUISIANA STATE UNIVERSITY

Financial Protection

ENROLLMENT/CHANGE FORM

[Reset Form](#)**FOR OFFICE USE ONLY**

Effective Date of Change: _____

HR/Payroll Rep: _____

Pay Type: _____

Campus: _____

Date Event Occurred: _____

Check the box for the Financial Protection benefit(s) you would like to enroll in or make changes to. All Employee and applicable dependent sections must be completely filled out in the event you are making changes. Descriptions of each Plan can be found on your HR's website. Contact your local HR/Benefit Staff for additional information.

TYPE OF CHANGE (REQUIRED)

- | | | |
|---|--------------------------------------|---|
| ☐ Birth/Adoption | ☐ New Hire | ☐ Death |
| ☐ Marriage | ☐ Emp Status | ☐ Divorce |
| ☐ Retirement | ☐ Termination | ☐ Add/Delete Dependent |
| ☐ Cancellation | ☐ Demographic | ☐ Change Other _____ |

Last Name		First Name		MI	Social Security #	
Mailing Address				City	State	Zip Code
Gender	Home Phone		Work Phone	Email Address		
Birth Date		Hire Date		Marital Date	Retirement Date	Annual Salary

☐ Add ☐ Delete		Last Name	First Name	MI	SSN	Gender	DOB
	SPOUSE						
	DEPENDENT						
	DEPENDENT						
	DEPENDENT						
	DEPENDENT						

TERM LIFE	Employee	☐ \$_____ Total coverage (must be in \$10,000 increments)				
	Spouse	☐ \$_____ Total coverage (must be in \$5,000 increments, not to exceed 50% of employee coverage)				
	Child(ren)	☐ \$5,000 (\$0.35/month) ☐ \$10,000 (\$0.70/month) ☐ \$15,000 (\$1.05/month) ☐ \$20,000 (\$1.40/month)				
	☐ I am enrolling in Life coverage		☐ I am cancelling Life coverage		Office Use Only SUBTOTAL:	

CRITICAL ILLNESS		Employee Only	Spouse 50% of EE/must be same option	Child(ren) 25% of Employee/must be same option
	Low Option	☐ \$10,000	☐ \$5,000	☐ \$2,500
	Mid Option	☐ \$20,000	☐ \$10,000	☐ \$5,000
	High Option	☐ \$30,000	☐ \$15,000	☐ \$7,500
	☐ I am enrolling in CI coverage		☐ I am cancelling CI coverage	

ACCIDENT	Level of Coverage	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
	Premium	☐ \$9.15	☐ \$13.60	☐ \$12.36	☐ \$16.81
	☐ I am enrolling in Accident coverage		☐ I am cancelling Accident coverage		Office Use Only SUBTOTAL:

LTD	Long Term Disability Calculation—\$_____ Monthly Salary x rate \$0.00311= \$_____ Monthly Premium			
	☐ I am enrolling in LTD coverage		☐ I am cancelling LTD coverage	

AD&D	☐ Employee	☐ \$27,500 (\$0.52/\$0.77)	☐ \$55,000 (\$1.05/\$1.54)	☐ \$82,500 (\$1.57/\$2.31)	☐ \$110,000 (\$2.09/\$3.08)
	☐ Family	☐ \$165,000 (\$3.14/\$4.62)	☐ \$220,000 (\$4.18/\$6.16)	☐ \$275,000 (\$5.23/\$7.70)	☐ \$300,000 (\$5.70/\$8.40)
	☐ I am enrolling in AD&D coverage		☐ I am cancelling AD&D coverage		Office Use Only SUBTOTAL:

Voluntary Life		
Age Bands	Rates per \$5,000	Rates per \$10,000
24 and under	\$0.16	\$0.32
25-29	\$0.20	\$0.39
30-34	\$0.23	\$0.45
35-39	\$0.29	\$0.57
40-44	\$0.36	\$0.71
45-49	\$0.50	\$1.00
50-54	\$0.85	\$1.70
55-59	\$1.30	\$2.60
60-64	\$1.97	\$3.94
65-69	\$3.25	\$6.50
70-74	\$6.12	\$12.23
75 and over	\$10.23	\$20.46
Employee rates based on Employee age Spouse rates based on Spouse age		



LOUISIANA STATE UNIVERSITY

Financial Protection Enrollment/Change Form

Last Name			First Name			MI		
Mailing Address								
City				State		Zip		
SSN				Birth Date				

Critical Illness		
Age Bands	Rates per \$5,000	Rates per \$10,000
24 and under	\$2.15	\$4.30
25-29	\$2.45	\$4.90
30-34	\$2.85	\$5.70
35-39	\$3.45	\$6.90
40-44	\$4.65	\$9.30
45-49	\$6.65	\$13.30
50-54	\$9.70	\$19.40
55-59	\$13.10	\$26.20
60-64	\$18.30	\$36.60
65-69	\$24.45	\$48.90
70-74	\$34.90	\$69.80
75 and over	\$45.25	\$90.50
Employee rates based on Employee age Spouse rates based on Employee age		

TERM LIFE	Primary Beneficiary Name(s)	Relationship	% of Benefit
	Contingent Beneficiary Name(s)	Relationship	% of Benefit
CRITICAL ILLNESS	Primary Beneficiary Name(s)	Relationship	% of Benefit
	Contingent Beneficiary Name(s)	Relationship	% of Benefit
ACCIDENT	Primary Beneficiary Name(s)	Relationship	% of Benefit
	Contingent Beneficiary Name(s)	Relationship	% of Benefit
AD&D	Primary Beneficiary Name(s)	Relationship	% of Benefit
	Contingent Beneficiary Name(s)	Relationship	% of Benefit

I authorize my employer to deduct from my wages the premiums, if any, for the elected coverage. To the best of my knowledge and belief, the information I have provided on this form is correct. I understand that any persons who knowingly present a false or fraudulent claim for payment of loss or benefit or knowingly present false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Employee Signature: _____

Date: _____