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~~ Reliastar	___New York Life	___Provident Universal	___UNUM Long Term Care
___ Employee ___ Empl AD&D ___ Spouse ___ Spouse AD&D ___ Children ___ Children AD&D	___ Employee ___ Employee plus one ___ Family 12 mo rate prem________	___ Employee ___ Employee plus one ___ Family 12 mo rate prem________	___ Employee ___ Spouse ___ Children 12 mo. rateprem ___	___ Employee ___ Employee & Spouse ___ Spouse
Ded Code 014	Ded Code ~~006~~ 0110	Ded Code 007	Ded Code 112	Ded Code 124

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

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

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

(___)______ (___)______ ______________________ ___/___/___
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
			___/___/___	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