Great-West® HEALTHCARE

Benefit Plan Enrollment/Change Form

ENROLLING

Enrollment for:
- ❑ Myself and my dependents (family coverage)
- ❑ Myself only (single coverage) because:
  - ❑ I have no dependents
  - ❑ My dependents have other insurance
  - ❑ I don't wish to purchase dependent coverage

Plan Selections:
- ❑ Basic Life
- ❑ AD&D

_____

DECLINING COVERAGE

Reason:
- ❑ I have other insurance
- ❑ I don't wish to purchase coverage

CHANGING INFORMATION

- ❑ Updating General Information
- ❑ Transferring to a different plan
- ❑ Adding a dependent

General Information (always complete this section)

Name Last	First	MI	Occupation
Street			Daytime Telephone (____)_____ Evening Telephone (____)_____
City	State	Zip Code	Email address _____
County	Date of Birth / /		**Marital Status:** ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed Date of Marriage ____/____/____
Social Security Number	Sex ❑ M ❑ F		

Life Insurance

If your employer is paying the full cost for this coverage, you are automatically covered under this benefit.

Beneficiary	Relationship	%
1.		
2.		
3.		

To be Completed by Employer

Company Name
LSU Agricultural Center

Date of Full-time Employment	Div/Location
Orig. Eff. Date of EE's Coverage	Orig. Eff. Date of Dep's Coverage

Earnings $ _____
❑ Hourly ❑ Weekly ❑ Monthly
❑ Bi-Monthly ❑ Yearly

Hours worked per week? _____

Is employee/dependent on COBRA continuation?
❑ Yes ❑ No

If Yes, attach copy of original COBRA enrollment form.

For Carrier Use Only

Plan Number 780113		Effective Date
Division	Late App	Class/Benefit Group

Dependent Information

Name (Last, First, M.I.)	Date of Birth (MM/DD/YYYY)	Relationship To Employee	Sex	Full-time Student
Spouse Social Security Number			❑ M ❑ F	
Child Social Security Number			❑ M ❑ F	❑ Yes ❑ No
Child Social Security Number			❑ M ❑ F	❑ Yes ❑ No
Child Social Security Number			❑ M ❑ F	❑ Yes ❑ No
Child Social Security Number			❑ M ❑ F	❑ Yes ❑ No

NOTE: Any person who, with intent to defraud or knowing that he is facilitating a fraud against a claims administrator of payer, submits an application or files a claim containing a false or deceptive statement is guilty of fraud. Such action is considered to be a felony in some states. ***By my signature below, I acknowledge that I have read and understand the disclosure on the back of this application. I authorize the required payroll deduction for contributory benefits. I also represent that all information shown on this application is correct.***

Employee Signature	Date (MM/DD/YYYY)

Disclosure Information

I hereby apply for all non-contributory coverages under my employer's plan and any contributory coverages that I have elected on the front of the application.

Life and or disability income coverage

I understand that I must satisfy the eligibility and actively at work requirements at my employer's usual place of business on the date coverage for myself and any eligible dependents becomes effective. If I am not actively at work, I understand that coverage for myself and life coverage for my eligible dependents may not become effective until I return to work. I will be considered a late applicant if I decline any contributory coverage offered under this application and later apply. As a late applicant applying for coverage, I understand that proof of good health may be required for myself and eligible dependents.

Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable.

For all coverages

I hereby authorize any insurance company, health care provider, or other entity or person having knowledge of anyone listed on this application to give this new carrier or their designated agent(s) any and all records pertaining to such person's medical history for purposes of review, investigation or evaluation. For application purposes, this authorization is valid for 24 months from the date I sign it. For purposes of claims, reimbursement and receipt of services rendered, this authorization is valid during the term of such person's coverage for evaluation of the nature and medical necessity of the services received. I am, or my authorized representative is, entitled to a copy of this signed authorization.

This Disclosure Information forms a part of the *Application for Membership* as fully as if it were contained over the applicant's signature.

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Louisiana residents - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and maybe subject to fines and confinement in prison.

Texas residents - Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and
confinement in state prison.

Residents of all other states - Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.