



**Louisiana State University System
Voluntary Life / Accidental Death & Dismemberment Enrollment Form**

EMPLOYEE INFORMATION

Employee Name	Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN
Employee Address	Date of Hire	Campus	
Spouse's Name	Spouse's Date of Birth	Employee's Base Annual Earnings / # of Hours Worked \$ _____ / _____	

LIFE COVERAGE SELECTION

Employee Life: Guaranteed Issue up to \$500,000 or 5 times Basic Annual Earnings in increments of \$10,000 with a maximum of \$1,000,000. Amounts over \$500,000 will be subject to Evidence of Insurability (E of I). Once covered, an employee may increase coverage by \$10,000 per year up to the applicable limits during Annual Enrollment, Guaranteed Issue.

Spouse Life: Upon Employee enrollment, up to \$100,000 of spousal coverage up to 1/2 of Employee coverage amount is available, Guaranteed Issue. Additional coverage up to 1/2 of the employee's life coverage is available in \$5,000 increments; subject to E of I.

Child(ren): Children ages 2 weeks to 6 months of age are covered for \$1,000, if selected. Check a coverage option below.

Age	Employee Rate / \$10,000	Spouse Rate / \$5,000	Coverage Selection		Premium Calculation						
			Life	Coverage	=	# Units	X	Rate	=	Mo. Amount	
<25	\$0.55	\$0.28									
25-29	\$0.65	\$0.33	Employee	\$	=	\$10,000	X		=		
30-34	\$0.75	\$0.38	Spouse	\$	=	\$5,000	X		=		
35-39	\$0.95	\$0.48	Child(ren)	<input type="checkbox"/> \$5,000 for each eligible dependent child \$0.75/mo. <input type="checkbox"/> \$10,000 for each eligible dependent child \$1.49/mo. <input type="checkbox"/> \$20,000 for each eligible dependent child \$2.98/mo.							
40-44	\$1.19	\$0.60									
45-49	\$1.68	\$0.84									
50-54	\$2.85	\$1.43	AD&D Coverage: Amount equal to life insurance coverage								
55-59	\$4.35	\$2.18	Employee	\$	=	\$10,000	X	\$0.31	=		
60-64	\$6.60	\$3.30	Spouse	\$	=	\$5,000	X	\$0.16	=		
65-69	\$10.90	\$5.45									
70-74	\$20.50	\$10.25									
75-79	\$34.30	\$17.15									
80-84	\$60.90	\$30.45									
85+	\$115.10	\$57.55									

BENEFICIARY INFORMATION *Designate your beneficiary(ies) below*

Primary Beneficiary(ies)

Name of Beneficiary (last name, first, mi)	SSN	Address	Relationship	Benefit %

Contingent Beneficiary(ies)

Name of Beneficiary (Last Name, First, MI)	SSN	Address	Relationship	Benefit %

Note: The beneficiary designation can be changed at any time by you. If you are married or divorced, you should consult with your legal counsel prior to changing your beneficiary. The designation takes effect as of the date the completed form is received and accepted by your employer.

READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW ▼

- I authorized my employer to deduct from my wages the premium, 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 person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**
- I understand my coverage begins on the effective date assigned by The Hartford Life, provided I am actively at work.
- I also understand that evidence of insurability may be required for coverage to become effective.
- In the event of any discrepancy between any of these documents and the policy, the terms of the policy apply. Complete coverage information is in the certificate of insurance booklet issued to each insured individual.

Employee's Signature	Date Signed	For Office Use	
		Pay Type	
		Monthly Deduct	
		Effective Date	