LAFAYETTE PARISH SCHOOL SYSTEM **INSURANCE DEPARTMENT**

Coverage Status Change Request

Employee Name_____ **SSN** _____
(Last) (First) (Int)

I request the following changes be made for *(Check all that apply)*:

_____ health insurance _____ life insurance _____dental insurance

_____ disability insurance _____ flexible spending _____ other

****

As a supplement to any previous application, I wish to make the changes indicated below **effective**_____
(Date)

Check all the applicable boxes below and provide the information needed

❑ **1.** Continue my coverage; however, ❑ add the dependents listed below.
❑ delete dependents listed below.

	Last Name	First Name	Initial	Sex	Birth date Mo. Day Yr.	SS#
Spouse						
Child						
Child						
Child						
Child						

State reason for change: _____

□ **2a.** Change my address to: _____

_____

□ **2b.** Change my name to: _____

Date of Marriage: _____ Date of Divorce: _____

□ **3.** Cancel coverage because: □ Employment terminated □ Other reason _____

□ **4.** Employee □ Will retire □ Has retired Effective _____
(Date)

Retirement system (Circle one): LTRS SERS

_____ _____
Today's date *Signature of subscriber*