LOUISIANA STATE UNIVERSITY

Louisiana State University
Office of Accounting Services
Payroll
204 Thomas Boyd Hall

EMPLOYEE REQUEST FOR MEDICAL INSURANCE ENROLLMENT CONFIRMATION FOR VESTING PURPOSES

AS545

Request Date _____

Employee _____ SSN _____

List other names primary insurance may have been carried under.

Ex: maiden or spouse's name

_____

_____

_____

Approximate Dates of Coverage _____ _____

_____ _____

Complete "Dependent" section only if confirmation is desired on the dependent(s).

Dependent's Name	Dependent's SSN	Approximate Dates of Coverage

Reason for Request: ☐ 2 Years until Retirement ☐ Agency Transfer ☐ Other *

Distribution of Information:

☐ Send to Department _____; Attn _____

☐ Mail to _____

_____

☐ This will be picked up. Call _____ when available.

* A $25 administrative fee must be paid in advance if confirmation is requested for any reason other than Retirement or Agency Transfer. Research will not commence until payment has been received.

_____ _____
Employee's Signature Date

Note: The Payroll Office will provide the requested information as quickly as possible but a definite turnaround time cannot be predicted due to the complex nature of the research required. Requests will be completed in order of receipt, unless the information is needed to complete an immediate retirement.

FOR ACCOUNTING SERVICES USE ONLY

☐ Mailed by _____ on _____ ☐ Sent to department

☐ Picked up by _____ on _____

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