

## STATE OF LOUISIANA - OFFICE OF GROUP BENEFITS - ENROLLMENT/CHANGE FORM (Page 1 of 2)

V1311													
Agency Number	Agency Name			Prir	Primary Plan Participant/Employee Name			Dat	Date of Hire				
Section 1 - Primary	Plan Partici	pant/ En	nployee In	format	ion								
Name First M.I. Last				Social Security Num			lumber	er Date			ate of Birth		
Home Phone number Work/Alt Phone Number				Email Address* (See footnote below)				l _		Gender			
Mailing Address (Street or P.O. Box)  City				City				State	Zip Code		Co	Country	
Physical Address (street) City				City				State	ate Zip Code		Co	Country	
Section 2 - Rehired I	Retiree												
When a retiree with OGB covera portion of the Re-employed Ret 1 Medicare, Retiree with 2 Medi premium will be the percentage resumes retirement. Retirees w	tiree premium fro care). At that tim e set at the retiree	m the date on the date of the agence of the	of hire. Upon res y from which the ement. For exar	uming ret e retiree o nple, an a	irement st riginally re gency pay	atus, premiums will natired will resume paying 19% of a retiree's	revert to the a ment of the premium up	pplicable employer on retiren ing to bei	retiree rate portion of nent will pa nefits-eligil	es (i.e. Retii the premiu ay 19% of the ble employ	ree witho um. The e he retiree	ut Medicare, Ret mployer portion	tiree with n of the
AGENCY RETIRED FROM					RETIREMENT DATE (MM/DD/YYYY)								
Section 3 - Enrollment Information													
LEVEL OF HEALTH AND LII For each dependent, employee section 5. If adding more than 4 Employee Only Empl	must check the b	oox in section ployee must	n 3 if they wish t	hat depen and subm	dent to ha	ive health and/or life	coverage. Fo	r life insur	ance, emp	loyee must	: also che	ck the appropria	ite box of
NAM (LAST, FIRST, MIDD			RELATION	SHIP	SEX	BIRTH DATE (MM/DD/YYYY)		D/DE- ETE	SOCIAL	SECURITY I	NUMBER	HEALTH	DEP. LIFE
SPOUSE								ADD DELETE				YES	YES
DEPENDENT					□ M □ F			ADD				YES	YES
DEPENDENT					☐ M ☐ F			ADD DELETE				YES	YES
DEPENDENT					M F			ADD DELETE				YES	YES
DEPENDENT					☐ M ☐ F			ADD				YES	YES
Section 4 - Health Pl	an Selectio	n											
COMPLETE THE APPLICAB	LE SECTION BE	LOW. SEL	ECT ONLY ON	E HEALT	H PLAN.								
			Active E	mploy	ees and	d Non-Medica	re Retire	es					
Pelican HRA1000 (Adminis Magnolia Local Plus (Admi Pelican HSA775* (Actives C \$ monthly deduction "If you select the Pelican Tax implications may ap	inistered by Blue ( Only - Administere n <b>HSA775 plan, y</b> o	Cross) ed by Blue Ci ou must con	ross)	☐ Magno	olia Open <i>i</i> rst Option	Limited Provider Net Access (Administerec 1 (for eligible LSU Ac ealth Savings Accou	l by Blue Cros ctive Employ	s) ees/ Non-l	Medicare R	etirees only		provided.	
				Λ	/ledica	re Retirees							
OGB Secondary Plans:  Pelican HRA1000 (Adminis  Magnolia Local Plus (Admi  Magnolia Open Access (According Coptional: Retiree 100)	inistered by Blue	Cross)				Limited Provider Net 3 (for eligible LSU Re		istered by	Blue Cross	s)			
☐ Employee Only ☐ Dependent Only ☐ Employee + 1 Dependent					MEDICARE VERIFICATION								
OGB Sponsored Medicare Advantage Plans:  Peoples Health Medicare Advantage Plan  Blue Advantage HMO  Humana Medicare Advantage Employer HMO Plan  Via Benefits (Please call 1-855-663-4228 or visit my.ViaBenefits.com/ogb to enroll.				to enroll.)	□ Ho □ Me □ Dru	□ No Coverage     □ No Coverage       □ Hospital (Part A)     □ Hospital (Part A)       □ Medical (Part B)     □ Medical (Part B)       □ Drugs (Part D)     □ Drugs (Part D)							
					Α	COPY OF MEDIC	ARE CARD I	NUST BE	ATTACH	ED			

\*Note to FSA Enrollees: By providing an email address, you may receive certain benefits-related correspondence through email unless you contact Optum Financial to receive paper notices. You are responsible to provide us with your current email address and to promptly notify us of any changes to your email address by calling customer service at 1-800-272-8451.



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OUISTAND										
Agency Number	Agency Name	Primary Plan Partici	pant/Employee Name	Social Security Number						
Section 5 - Lif	e and Flexible Benefits Plan Selection	on								
LIFE INSURANCE (che	eck one only) OGB FLEXIBLE BENEFITS (check all that SURANCE COVERAGE									
BASIC BASIC PLUS SUPPLEMENTAL										
☐ Employee/Depe Eligible Spouse ☐ Employee/Depe	\$1,000 Eligible Child \$500		☐ Employee/No Dependent Coverage ☐ Employee/Dependent Coverage ☐ Eligible Spouse \$2,000 Eligible Child \$1,000 ☐ Employee/Dependent Coverage ☐ Eligible Spouse \$4,000 Eligible Child \$2,000							
Annual Salary	Annual Salary Date of Last Salary Increase Face Life									
FLEXIBLE BENEFITS (ACTIVE EMPLOYEES ONLY)										
□ Decline flexible spending account □ My agency does not participate in OGB's flexible benefits plan □ I do want to participate and acknowledge that I have completed the flexible spending arrangement form.										
Section 6 - Ac	knowledge Offer and Decline Healt	h Insurance Co	verage (Active Employ	ees Only)						
I have been offered h health coverage at a event I, or my eligible <b>Reason for Declinin</b>	OFFER AND DECLINE HEALTH INSURANCE COVER ealth coverage for myself and my eligible depender later date, I understand that I may only enroll for hea e dependents have a Plan Recognized Qualified Life g Health Coverage Offer:	nts. I have voluntarily alth coverage during Event.	elected to decline the coverage a annual enrollment or as otherwis							
□ Other Group Health Coverage (would include being covered as a dependent under an OGB plan) □ Other Individual Health Coverage □ Medicare, Medicaid, Other, Explain: □ I am not enrolled in any health coverage and I do not accept this offer of health coverage □ I do not wish to disclose  NOTE TO AGENCY REPRESENTATIVE: If the employee declines health coverage, he or she must acknowledge the offer of coverage by completing the GB-01 form. The acknowledgment must be sent to OGB and a copy retained by the agency participating employer as evidence that the employee was offered health coverage within the time-frames allowed by law and the employee subsequently declined the offer of coverage.										
Section 7 - Ac	knowledgment and Certification									
(Please check each b	Participant, acknowledge that I have provided appronts are included with this application. icipation or a change in my participation in the nam and authorize deductions from my earnings or retinand certify that the information provided on this for y result in denial or rescission of coverage retroactive is acknowledgment and certification will become a that any dis-enrollment from an OGB plan of benefit	ed plan(s) and agree ement check to pay for rm is true and correct re to the initial day of part of my application	to be bound by the plan's terms a or insurance for myself and my de I understand that if I provide fals coverage. n for coverage and that a copy of	and conditions. ependents, if ap e, misleading c	oplicable. or incomplete information on s as valid as the original.					
Signature				Date						
FOR AGENCY USE										
	NIZED QUALIFIED LIFE EVENT (QLE) FOR	R APPLICATION (		DSHEET):						
QLE code or qualified life event des		die appropriete en l	Qualified life event date		ate Coverage					
I, Agency Repr referenced abo	esentative, certify that the documentation presente ove.	d is appropriate and s	supports the occurrence of the O	GB plan-recogr	nized qualified life event					
Signature of Agenc	y Representative				Date					
Printed Name of Ag		Date								

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