



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

Agency Number, Agency Name, Primary Plan Participant/Employee Name, Date of Hire

Section 1 - Primary Plan Participant/ Employee Information. Fields for Name First, M.I., Last, Social Security Number, Date of Birth, Home Phone number, Work/Alt Phone Number, Email Address*, Gender, Mailing Address, Physical Address.

Section 2 - Rehired Retiree

When a retiree with OGB coverage returns to benefits-eligible employment, the hiring agency must notify OGB within 30 days of reemployment and the hiring agency must begin to pay the employer portion of the Re-employed Retiree premium from the date of hire.

AGENCY RETIRED FROM, RETIREMENT DATE (MM/DD/YYYY)

Section 3 - Enrollment Information

LEVEL OF HEALTH AND LIFE COVERAGE - FOR PLAN SELECTION SEE SECTIONS 4 AND 5

For each dependent, employee must check the box in section 3 if they wish that dependent to have health and/or life coverage. For life insurance, employee must also check the appropriate box of section 5.

Employee Only, Employee + Child(ren), Employee + Spouse, Family

Table with columns: NAME, RELATIONSHIP, SEX, BIRTH DATE, ADD/DELETE, SOCIAL SECURITY NUMBER, HEALTH, DEP. LIFE. Rows for SPOUSE and four DEPENDENT entries.

Section 4 - Health Plan Selection

COMPLETE THE APPLICABLE SECTION BELOW. SELECT ONLY ONE HEALTH PLAN.

Active Employees and Non-Medicare Retirees. Options for Pelican HRA1000, Magnolia Local Plus, Pelican HSA775, Magnolia Local, Magnolia Open Access, LSU First Option 1.

Medicare Retirees

OGB Secondary Plans, OGB Sponsored Medicare Advantage Plans, Medicare Verification table, A COPY OF MEDICARE CARD MUST BE ATTACHED



Agency Number	Agency Name	Primary Plan Participant/Employee Name	Social Security Number
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Section 5 - Life and Flexible Benefits Plan Selection

LIFE INSURANCE (check one only) OGB FLEXIBLE BENEFITS (check all that apply)

DECLINE LIFE INSURANCE COVERAGE

BASIC	BASIC PLUS SUPPLEMENTAL
<input type="checkbox"/> Employee/No Dependent Coverage <input type="checkbox"/> Employee/Dependent Coverage Eligible Spouse \$1,000 Eligible Child \$500 <input type="checkbox"/> Employee/Dependent Coverage Eligible Spouse \$2,000 Eligible Child \$1,000	<input type="checkbox"/> Employee/No Dependent Coverage <input type="checkbox"/> Employee/Dependent Coverage Eligible Spouse \$2,000 Eligible Child \$1,000 <input type="checkbox"/> Employee/Dependent Coverage Eligible Spouse \$4,000 Eligible Child \$2,000

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 - Acknowledge Offer and Decline Health Insurance Coverage (Active Employees Only)

ACKNOWLEDGE OFFER AND DECLINE HEALTH INSURANCE COVERAGE (ACTIVE EMPLOYEES ONLY)

I have been offered health coverage for myself and my eligible dependents. I have voluntarily elected to decline the coverage as indicated below. If I choose to apply for health coverage at a later date, I understand that I may only enroll for health coverage during annual enrollment or as otherwise specified in the OGB plan document in the event I, or my eligible dependents have a Plan Recognized Qualified Life Event.

Reason for Declining Health Coverage Offer:

- 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 - Acknowledgment and Certification

BY SIGNING THIS APPLICATION, I ACKNOWLEDGE AND CERTIFY THE FOLLOWING:

(Please check each box)

- I, Primary Plan Participant, acknowledge that I have provided appropriate documents to ogb to verify my eligibility and the eligibility of my covered dependent(s) and those documents are included with this application.
 I apply for participation or a change in my participation in the named plan(s) and agree to be bound by the plan's terms and conditions.
 I acknowledge and authorize deductions from my earnings or retirement check to pay for insurance for myself and my dependents, if applicable.
 I acknowledge and certify that the information provided on this form is true and correct I understand that if I provide false, misleading or incomplete information on this form, it may result in denial or rescission of coverage retroactive to the initial day of coverage.
 I accept that this acknowledgment and certification will become a part of my application for coverage and that a copy of my signature is as valid as the original.
 I acknowledge that any dis-enrollment from an OGB plan of benefits will result in dis-enrollment from both medical and pharmacy benefits, including, but not limited to, Medicare Part D.

Signature	Date
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FOR AGENCY USE

PLAN RECOGNIZED QUALIFIED LIFE EVENT (QLE) FOR APPLICATION (REFERENCE 2023 QLE SPREADSHEET):

QLE code or qualified life event description	Qualified life event date	Add/Drop/Reinstate Coverage <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Reinstate Coverage
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I, Agency Representative, certify that the documentation presented is appropriate and supports the occurrence of the OGB plan-recognized qualified life event referenced above.

Signature of Agency Representative	Date
Printed Name of Agency Representative	Date