



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

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

Section 4 - Health Plan Selection

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

Active Employees and Non-Medicare Retirees

- Pelican HRA1000, Magnolia Local, Magnolia Local Plus, Magnolia Open Access, Pelican HSA775, LSU First Option 1

\$ monthly deduction

If you select the Pelican HSA775 plan, you must complete the GB-79 form to open a Health Savings Account in your name with a minimum deposit of \$200 provided.

Tax implications may apply for certain members.

Medicare Retirees

OGB Secondary Plans:

- Pelican HRA1000, Magnolia Local, Magnolia Local Plus, Magnolia Open Access, LSU First Option 3

Optional: Retiree 100

- Employee Only, Dependent Only, Employee + 1 Dependent

OGB Sponsored Medicare Advantage Plans:

- Peoples Health Medicare Advantage Plan, Blue Advantage HMO, Humana Medicare Advantage Employer HMO Plan

MEDICARE VERIFICATION table with No Coverage, Hospital (Part A), Medical (Part B), Drugs (Part D) options

A COPY OF MEDICARE CARD MUST BE ATTACHED

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.



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

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