13500	
(and	
(OSD)	
STRIBER	

MAILING ADDRESS (IF DIFFERENT)

HOME PHONE NUMBER

CITY

EMAIL ADDRESS

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	
				<u> </u>	
Section 1 –Primary Plan Participant / Employee Information					
ALANE (LAST SIDET AND DESIGNATION)			50 5111 5551 1979 1111 1155	To 175 05010711	
NAME (LAST, FIRST, MIDDLE INITIAL)		NAME CHANGE	SOCIAL SECURITY NUMBER	DATE OFBIRTH	
		□Y □N			
PHYSICAL ADDRESS		_	CITY	STATE	ZIP CODE

Section 2 - Enrollment Information

LEVEL OF HEALTH AND LIFE COVERAGE - FOR PLAN SELECTION SEE SECTIONS 3 AND 4.

WORK / ALT PHONE NUMBER

For each dependent, employee must check the box in section 2 if they wish that dependent to have health and/or life coverage. For life insurance, employee must also check the appropriate box of section 4. If adding more than 4 dependents, employee must complete, sign and submit a second GB-01 form.

□Employee Only □Employee + Child(ren)	□Employee + Spouse	□Family					
NAME (LAST, FIRST, MIDDLE INITIAL)	RELATIONSHIP	SEX	BIRTH DATE (MM/DD/YYYY)	ADD/ DELETE	SOCIAL SECURITY NUMBER	HEALTH	DEP. LIFE
SPOUSE		□M □F		□ADD □DELETE		□YES	□YES
DEPENDENT		□M □F		□ADD □DELETE		□YES	□YES
DEPENDENT		□M □F		□ADD □DELETE		□YES	□YES
DEPENDENT		□M □F		□ADD □DELETE		□YES	□YES
DEPENDENT		□M □F		□ADD □DELETE		□YES	□YES

Section 3 -Health Plan Selection

☐One Exchange (Enrollment is conducted through One Exchange. (Please call 1-855-663-4228 or visit medicare.oneexchange.com/ogb to enroll)

DWIPLETE THE APPLICABLE SECTION BELOW. SELECT ONLY ONE HEALTH PLAN.				
Active Emp	loyees and Non-Medi	icare Retirees		
☐Pelican HRA 1000 (Administered by Blue Cross) ☐Magnolia Local Plus (Administered by Blue Cross) ☐Magnolia Open Access (Administered by Blue Cross)	9		work - Administered by BI) (Insured by Vantage Hea	
□Pelican HSA 775* (Actives Only -Administered by Blue Cross) \$ monthly deduction *If you select the Pelican HSA 775 plan, you must complete the \$200 provided. Tax implications may apply for certain members	GB-79 form to open a Heal	. 3	ctive/Non-Medicare Retire	•
	Medicare Retirees			
OGB Secondary Plans: □Pelican HRA 1000 (Administered by Blue Cross) □Magnolia Local Plus (Administered by Blue Cross) □Magnolia Open Access (Administered by Blue Cross) Optional: Retiree 100 □Employee Only □Dependent Only □Employee + 1 Dependent	,	ne HMO (MHHP) (Insure	dministered by Blue Cross d by Vantage Health Plan) nly)	•
OGB Sponsored Medicare Advantage Plans: Retiree and all covered dependents must have both Medicare A and Medicare B Vantage Medicare Advantage Premium HMO-POS Plan		MEDICARE VERIFICATION EMPLOYEE SPOUSE		
□ Vantage Medicare Advantage Standard HMO-POS Plan □ Vantage Medicare Advantage Basic HMO-POS Plan □ Peoples Health Medicare Advantage Plan □ Blue Advantage HMO □ Humana Medicare Advantage Employer HMO Plan		□No Coverage □Hospital (Part A) □Medical (Part B) □Drugs (Part D)	□No Coverage □Hospital (Part A) □Medical (Part B) □Drugs (Part D)	
The first the care reasonable to the control of the		A COPY OF MEDICARI	E CARD MUST BE ATTACHED	1

STATE

ZIP CODE

SEX □м □ғ



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

AGENCY NUMBER	AGENCY NAME	PRIMARY PLAN PARTICIPANT / EMPLOYEE NAME	SOCIAL SECURITY NUMBER

Section 4 –Life and Flexible Benefits Plan Selection

LIFE INSURANCE (check one only)

□ DECLINE LIFE INSURANCE COVERAGE

BASIC	BASIC PLUS SUPPLEMENTAL
□Employee/No Dependent Coverage □Employee/Dependent Coverage Eligible Spouse \$1000 Eligible Child \$500 □Employee/Dependent Coverage Eligible Spouse \$2000 Eligible Child \$1000	□Employee/No Dependent Coverage □Employee/Dependent Coverage Eligible Spouse \$2000 Eligible Child \$1000 □Employee/Dependent Coverage Eligible Spouse \$4000 Eligible Child \$2000
Annual Salary Date of Last Salary In	crease Face Life

OGB FLEXIBLE BENEFITS (check all that apply)

Flexible Benefits (Actives Only)
☐Decline Flexible Spending Account(s)
☐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 Enrollment
Form.

Section 5 – Acknowledge Offer and Decline Health Insurance Coverage

☐ ACKNOWLEDGE OFFER AND DECLINE HEALTH INSURANCE COVERAGE

I have been offered health coverage for me 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 health plan document in the event I, or my eligible dependents have a Plan Recognized Qualified Life Event.

Important: The Affordable Care Act requires each individual to have basic health insurance coverage (known as minimum essential coverage), qualify for an exemption, or make a shared responsibility payment when filing his/her federal income tax return. Failure to enroll in an OGB plan or obtain other minimum essential coverage may result in personal financial penalties.

Reason for Declining Health Insurance Offer:

Other Group Health Coverage (would include being covered as a dependent under an OGB plan)

□Other Individual Health Coverage

Agency Representative Signature

□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 in a method determined by the agency participating employer. The acknowledgment must be retained by the agency participating employer as evidence that the employee was offered health coverage within the timeframes allowed by law and the employee subsequently declined the offer of coverage.

Section 6 – Acknowledgment and Certification

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

- > I, Primary Plan Participant, acknowledge that I have provided appropriate documents to OGB to verify my eligibility and the eligibility any requested covered dependents 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 as 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 disenrollment from an OGB Plan of Benefits will result in disenrollment from both medical and pharmacy benefits, including, but not limited to, Medicare Part D.

rimary Plan Participant / Employee Da	ite	
FOR AGENCY USE ONLY:		
Plan Recognized Qualified Life Event (QLE) for App	Dlication (REFERENCE OGB 2016	QLE SPREADSHEET):
QLE CODE OR QUALIFIED LIFE EVENT DESCRIPTION	QUALIFIED EVENT DATE	ADD/DROP/REINSTATE COVERAGE □ADD □DROP □REINSTATE COVERAGE
I, Agency Representative, certify that the documentation presented is appropriate Life Event referenced above.	and supports the occurrence of the OGB	Plan-Recognized Qualified

Date