





AGENCY NUMBER	AGENCY NAME	PRIMARY PLAN PARTICIPANT / EMPLOYEE NAME	SOCIAL SECURITY NUMBER
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**Section 4 –Life and Flexible Benefits Plan Selection**

**LIFE INSURANCE (check one only)**

**OGB FLEXIBLE BENEFITS (check all that apply)**

BASIC	BASIC PLUS SUPPLEMENTAL
<input type="checkbox"/> Employee/No Dependent Coverage <input type="checkbox"/> Employee/Dependent Coverage Eligible Spouse \$1000 Eligible Child \$500 <input type="checkbox"/> Employee/Dependent Coverage Eligible Spouse \$2000 Eligible Child \$1000	<input type="checkbox"/> Employee/No Dependent Coverage <input type="checkbox"/> Employee/Dependent Coverage Eligible Spouse \$2000 Eligible Child \$1000 <input type="checkbox"/> Employee/Dependent Coverage Eligible Spouse \$4000 Eligible Child \$2000
Annual Salary _____ Date of Last Salary Increase _____ Face Life _____	

Flexible Benefits (Actives Only)
<input type="checkbox"/> Decline Flexible Spending Account(s) <input type="checkbox"/> My Agency Does Not Participate in OGB's Flexible Benefits Plan <input type="checkbox"/> 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
- 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.

\_\_\_\_\_  
Primary Plan Participant / Employee

\_\_\_\_\_  
Date

**FOR AGENCY USE ONLY:**

**Plan Recognized Qualified Life Event (QLE) for Application** (REFERENCE OGB 2016 QLE SPREADSHEET):

QLE CODE OR QUALIFIED LIFE EVENT DESCRIPTION	QUALIFIED 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.**

\_\_\_\_\_  
Agency Representative Signature

\_\_\_\_\_  
Date