STATE OF LOUISIANA - OFFICE OF GROUP BENEFITS - ENROLLMENT/CHANGE FORM

AGENCY NUMBER	AGENCY NAME	PRIMARY PLAN PARTICIPANT / EMPLOYEE NAME	DATE OF HIRE

Section 1 – Primary Plan Participant / Employee Information

NAME (LAST, FIRST, MIDDLE INITIAL)	NAME CHANGE ☐Y ☐N	SOCIAL SECURITY NUMBER	DATE OFBIRTH

PHYSICAL ADDRESS	CITY	STATE	ZIP CODE

MAILING ADDRESS (IF DIFFERENT)	CITY	STATE	ZIP CODE

HOME PHONE NUMBER	WORK / ALT PHONE NUMBER	EMAIL ADDRESS	SEX
( )	( )		☐M ☐F

Section 2 – Enrollment Information

LEVEL OF HEALTH AND LIFE COVERAGE – FOR PLAN SELECTION SEE SECTIONS THREE AND FOUR.

(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

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

Active Employees and Non-Medicare Retirees

☐Pelican HRA 1000 (Administered by Blue Cross)
☐Magnolia Local Plus (Administered by Blue Cross)
☐Magnolia Open Access (Administered by Blue Cross)
☐Pelican HSA 775 (Actives Only -Administered by Blue Cross)
$_____ HSA monthly deduction
☐Magnolia Local (Limited Provider Network - Administered by Blue Cross)
☐Vantage Medical Home HMO (MHHP) (Insured by Vantage Health Plan)(HMO-POS)
☐LSU First Option 1 (for Eligible LSU Active/Non-Medicare Retirees only)
☐LSU First Option 2 (for Eligible LSU Active/Non-Medicare Retirees only)

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*
☐Magnolia Local (Limited Provider Network - Administered by Blue Cross)
☐Vantage Medical Home HMO (MHHP) (Insured by Vantage Health Plan)(HMO-POS)
☐LSU First Option 1 (for Eligible LSU retirees only)
☐LSU First Option 2 (for Eligible LSU retirees only)

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
☐Vantage Medicare Advantage HMO-POS Plan
☐Vantage Medicare Advantage Zero Premium Plan
☐Peoples Health Medicare Advantage Plan
☐One Exchange (Enrollment is conducted through One Exchange.
(Please call 1-855-663-4228 or visit medicare.oneexchange.com/ogb to enroll)

MEDICARE VERIFICATION	
EMPLOYEE	SPOUSE
☐No Coverage ☐Hospital (Part A) ☐Medical (Part B) ☐Drugs (Part D)	☐No Coverage ☐Hospital (Part A) ☐Medical (Part B) ☐Drugs (Part D)
A COPY OF MEDICARE CARD MUST BE ATTACHED	

Agency – Continue completing form on page 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 Increase _____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
☐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 acknowledgement must be retained by the agency participating employer as evidence the employee was offered health coverage within 30 days of eligibility and the employee subsequently declined the offer of coverage.

Section 6 – Authorization

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 eligibility of myself and 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 Acknowledgement 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, including, but not limited to Medicare Part D.

Primary Plan Participant / Employee Date

FOR AGENCY USE ONLY:

OGB 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
		☐ADD ☐DROP ☐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