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* (See footnote below)	Gender
			☐ Male ☐ Female

Mailing Address (Street or P.O. Box)	City	State	Zip Code	Country

Physical Address (street)	City	State	Zip Code	Country

☐ If this is a new or updated address, please check this box.

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. Upon resuming retirement status, premiums will revert to the applicable retiree rates (i.e. Retiree without Medicare, Retiree with 1 Medicare, Retiree with 2 Medicare). At that time, the agency from which the retiree originally retired will resume payment of the employer portion of the premium. The employer portion of the premium will be the percentage set at the retiree's initial retirement. For example, an agency paying 19% of a retiree's premium upon retirement will pay 19% of the retiree's premium when the retiree resumes retirement. Retirees who have maintained their OGB health coverage in retirement MAY NOT waive coverage when returning to benefits-eligible employment.

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. 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	GENDER	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 4 - Health Plan Selection - COMPLETE THE APPLICABLE SECTION BELOW. SELECT ONLY ONE HEALTH PLAN.

Active Employees and Non-Medicare Retirees

☐ Pelican HRA1000 (Administered by Blue Cross)
☐ Magnolia Local Plus (Administered by Blue Cross)
☐ Pelican HSA775* (Actives Only - Administered by Blue Cross)
$ _____monthly deduction

☐ Magnolia Local (Limited Provider Network - Administered by Blue Cross)
☐ Magnolia Open Access (Administered by Blue Cross)
☐ LSU First Option 1 (for eligible LSU Active Employees/ Non-Medicare Retirees only)

***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 (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

OGB Sponsored Medicare Advantage Plans:

☐ Peoples Health Medicare Advantage Plan
☐ Blue Advantage HMO
☐ Humana Medicare Advantage Employer HMO Plan
Via Benefits (Please call 1-855-663-4228 or visit my.ViaBenefits.com/ogb to enroll.)

☐ Magnolia Local (Limited Provider Network - Administered by Blue Cross)
☐ LSU First Option 3 (for eligible LSU Retirees only)

MEDICARE VERIFICATION	
PLAN MEMBER	**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	

***Note to FSA Enrollees:** *By providing an email address, you may receive certain benefits-related correspondence through email unless you contact TASC to receive paper notices. You are responsible to provide us with your current email address and to promptly notify us of any changes to your email address by calling customer service at 1-800-272-8451.*

Agency- Continue Completing on page 2

Agency Number	Agency Name	Primary Plan Participant/Employee Name	Social Security Number

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	ENHANCED BASIC
☐ Employee/No Dependent Coverage ☐ Employee/Dependent Coverage (Eligible Spouse $1,000 Eligible Child $500) ☐ Employee/Dependent Coverage (Eligible Spouse $2,000 Eligible Child $1,000)	☐ Employee/No Dependent Coverage ☐ Employee/Dependent Coverage (Eligible Spouse $1,000 Eligible Child $500) ☐ Employee/Dependent Coverage (Eligible Spouse $2,000 Eligible Child $1,000)

BASIC PLUS SUPPLEMENTAL
☐ Employee/No Dependent Coverage ☐ Employee/Dependent Coverage (Eligible Spouse $2,000 Eligible Child $1,000) ☐ 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.

CERTIFICATION:

☐ I do not have OGB health coverage as a retiree

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, TRICARE/Veteran's Administration or Other, Explain:
☐ I am not enrolled in any health coverage and I do not accept this offer of health coverage

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

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
		☐ 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.
If the QLE referenced above is for retirement, I further certify that the individual meets the retiree eligibility requirements set forth in OGB's rules.

Signature of Agency Representative	Date
Printed Name of Agency Representative	**Date**