

## STATE OF LOUISIANA - OFFICE OF GROUP BENEFITS - ENROLLMENT/CHANGE FORM (Page 1 of 2)

Agency Number	Agency Name			P	Primary Plan Participant/Employee Name				Date of Hire						
Section 1 - Primary	Plan Partici	pant/ E	mployee In	forma	ation										
Name First M.I.			Last		Social Security Nun			nber	er Date		te of Birth				
Home Phone number Work/Alt Pho			one Number			Email Address* (See footnote below)			Gender		er ale				
Mailing Address (Street or P.O. Box)				City				State	tate Zip Code		Country				
Physical Address (street)				City				State	Zip Code		Country				
Section 2 - Rehired	Retiree														
When a retiree with OGB cover portion of the premium. Upon Retirees who took their OGB he	returning to retire	ement, pren	miums will revert l	back to t	he retireme	nt rates and the origi	nal retiring age	ncy will resi							
AGENCY RETIRED FROM									ETIREMENT DATE (MM/DD/YYYY)						
Section 3 - Enrollmo	ent Informat	tion													
LEVEL OF HEALTH AND LI For each dependent, employed section 4. If adding more than Employee Only Emp	e must check the b	oox in section	on 3 if they wish t	that depe	endent to ha mit a second	ve health and/or life	coverage. For I	fe insuranc	e, employee	e must also	check t	the appropria	ite box of		
NAN (LAST, FIRST, MID			RELATION	ISHIP	SEX	BIRTH DATI	E ADD	1 5	OCIAL SECU	JRITY NUME	3ER	HEALTH	DEP. LIFE		
SPOUSE							AC DEL					YES	YES		
DEPENDENT					□ <sup>M</sup>		☐ AC	I				YES	YES		
DEPENDENT							AC DEL	I .				YES	YES		
DEPENDENT					M F		☐ AC					YES	YES		
DEPENDENT					M F		AC DEL	<b>I</b>				YES	YES		
Section 4 - Health P	lan Selectio	n													
COMPLETE THE APPLICAE	SLE SECTION BE	ELOW. SEI	LECT ONLY ON	E HEAL	TH PLAN.										
			Active E	mplo	yees and	d Non-Medica	re Retiree	5							
Pelican HRA1000 (Admini Magnolia Local Plus (Adm Magnolia Open Access (A Pelican HSA775* (Actives monthly deduction if you select the Pelican Tax implications may approximate the property of the property of the pelican Tax implications may approximate the pelican the pelican that implications may approximate the pelican that implications may be approximate the pelican that implications may approximate the pelican that implications m	ninistered by Blue ( dministered by Blu Only - Administere on n <b>HSA775 plan, yo</b>	Cross) ue Cross) ed by Blue C ou must co	Cross)	☐ Vanta	age Medical First Option	Limited Provider Net Home HMO (MHHP) 1 (for eligible LSU Ac ealth Savings Accou	(Insured by Va tive Employees	ntage Healt / Non-Medi	h Plan) (HM care Retiree	es only)	200 pro	ovided.			
					Medica	re Retirees									
OGB Secondary Plans:  Pelican HRA1000 (Admini Magnolia Local Plus (Adm Magnolia Open Access (A Optional: Retiree 100 Employee Only De	ninistered by Blue ( dministered by Blu	Cross) ue Cross)		☐ Vant	age Medical	Limited Provider Net Home HMO (MHHP) 3 (for eligible LSU Re MEDICA	(Insured by Va	ntage Healt		O-POS)					
OGB Sponsored Medicare Advantage Plans: Vantage Medicare Advantage Premium HMO-POS Plan Vantage Medicare Advantage Standard HMO-POS Plan Vantage Medicare Advantage Basic HMO-POS Plan Peoples Health Medicare Advantage Plan Blue Advantage HMO				□ Ho □ Me □ Dru	□ No Coverage □ Hospital (Part A) □ Medical (Part B) □ Drugs (Part D)  ■ COPY OF MEDICARE CARD MUST BE ATTACHED										
Humana Medicare Advantage Employer HMO Plan Via Benefits (Please call 1-855-663-4228 or visit my.ViaBenefits.com/ogb t					l.)										

\*Note to FSA Enrollees: By providing an email address, you may receive certain benefits-related correspondence through email unless you contact DataPath Administrative Services 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.



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OUISTANA									
Agency Number	Agency Name	Primary Plan Participan	t/Employee	e Name		Social Security Number			
Section 5 - Life	e and Flexible Benefits	Plan Selection	on						
	ck one only) OGB FLEXIBLE BENI SURANCE COVERAGE	EFITS (check all that	apply)						
BASIC			PLUS SUPPLEMENTAL		FLEXIBLE BENEFITS (ACTIVE EMPLOYEES ONLY)				
Employee/Deper	\$1,000 Eligible Child \$500	☐ 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			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.				
Annual Salary Date of Last Salary Increase			Face Life		1				
Section 6 - Ac	knowledge Offer and I	Decline Healt	h Insurance Cove	rage (A	tive Employee	es Only)			
coverage at a later da my eligible depender Reason for Declining Other Group Healt Other Individual H Medicare, Medicai I am not enrolled i I do not wish to dis NOTE TO AGENCY RE acknowledgment mu frames allowed by lav	te, I understand that I may only only only only only only only onl	enroll for health covered as a dependence of the Event.  g covered as a dependence of accept this offer the edeclines health coained by the agence of the offer the of	verage during annual enro endent under an OGB pla of health coverage overage, he or she must a cy participating employer	ollment or a	e the offer of coverage	d in the OGI	low. If I choose to apply for health B plan document in the event I, or eting the GB-01 form. The health coverage within the time-		
			E FOLLOWING:						
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 to 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 thi	is acknowledgment and certifica	tion will become a	part of my application fo	r coverage	and that a copy of my	y signature i	s as valid as the original.		
I acknowledge to, Medicare Pa	that any dis-enrollment from an rt D.	OGB plan of benefi	ts will result in dis-enrollr	nent from I	ooth medical and pha	armacy ben	efits, including, but not limited		
Signature					Date	e			
FOR AGENCY USE									
PLAN RECOGN	IIZED QUALIFIED LIFE EV	ENT (QLE) FOR	R APPLICATION (REF	ERENCE 2	019 QLE SPREADSH	HEET):			
QLE code or qualified life event descr	iption			Qualified life event	date	Add/Drop/Reinsta	te Coverage ate Coverage		
I, Agency Repre referenced abo	esentative, certify that the docunve.	nentation presented	d is appropriate and supp	oorts the oo	currence of the OGB	plan-recogi	nized qualified life event		
Signature of Agency	Representative					Date			
Printed Name of Agency Representative							Date		