



STATE OF LOUISIANA - OFFICE OF GROUP BENEFITS - RETIREMENT ELIGIBILITY ATTESTATION FORM

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, Gender, Mailing Address, Physical Address, City, State, Zip Code, Country

Section 2 - Retirement Information

Prior to retirement an employee MUST do the following: Be enrolled in OGB health coverage immediately prior to your retirement; and, Check years of participation; and, Make payment arrangements for your post-retirement premiums.

Section 3 - Participation Information

The State's share of your post-retirement premiums will be based on the number of years that you participated in OGB health coverage if you: (i) started participation in OGB before January 1, 2002 and have not maintained continuous OGB coverage, or (ii) started participation in OGB on or after January 1, 2002:

Table with 2 columns: YEARS OF OGB PLAN PARTICIPATION, STATE'S SHARE OF TOTAL MONTHLY PREMIUM. Rows include 20 years or more (75 percent), 15 years but less than 20 years (56 percent), 10 years but less than 15 years (38 percent), Less than 10 years (19 percent).

Remember: Your years of working for the State or participating in a retirement program ARE NOT the same as years of participation in OGB health coverage. Your premium share in retirement will be based on your years of participation in OGB health coverage, which could be different from the number of years you worked for the State. Contact OGB immediately if you believe your participation summary is incorrect.

Section 4 - Participation Attestation

PARTICIPATION RATE (check one only) 20+ years (75% state share), 15 -19 years (56% state share), 10 - 14 years (38% state share), 1-9 years (19% state share). Please Note: At the date of retirement, participation credits can no longer be earned.

Section 5 - Retain or Decline Coverage in Retirement

Keeping your coverage in retirement is not required but there are some things to keep in mind if you are considering dropping your coverage: If you drop your OGB health coverage, at or during retirement, you can NEVER have OGB health coverage again! If you are eligible for Medicare, DON'T sign up for a Medicare Advantage, Medigap, or Medicare Part D plan that is not offered through OGB. If you do, you will be dropped from OGB and lose your OGB health coverage. If you are considering a new Medicare plan, contact OGB before signing up to find out if it is an OGB-sponsored plan. I understand the provisions of retiree eligibility and premiums and wish to continue health or life insurance coverage as a retiree. I understand the provisions of retiree eligibility and premiums and wish to continue both health and life insurance coverage as a retiree. I wish to cancel my health or life insurance coverage due to retirement and understand that I will not be eligible to re-enroll in the future. I wish to cancel both my health and life insurance coverage due to retirement and understand that I will not be eligible to re-enroll in the future.

Section 6 - 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 been made aware of my participation rate by my HR representative and understand the percentage the state will pay on my health care premiums. I acknowledge and understand that once retired, participation credits can no longer be earned. I acknowledge and authorize deductions from my retirement check to pay for insurance for myself and my dependents, if applicable. I accept that this acknowledgment and certification will become a part of my application to continue coverage and that a copy of my signature is as valid as the original.

Employee Signature, Date

Section 7 - Agency Attestation - Plan Recognized Qualified Life Event (QLE) For Application (Reference 2023 QLE Spreadsheet)

QLE code or qualified life event description, Qualified life event date, Signature of Agency Representative, Date, Printed Name of Agency Representative