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
			☐ Male ☐ Female

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

Physical Address (street)	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:

RETIREE PARTICIPATION SCHEDULE	
YEARS OF OGB PLAN PARTICIPATION	**STATE'S SHARE OF TOTAL MONTHLY PREMIUM**
20 years or more	**75 percent**
15 years but less than 20 years	**56 percent**
10 years but less that 15 years	**38 percent**
Less than 10 years	**19 percent**
This schedule applies to both OGB and LSU First health plan participants	

- » **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 coverage as a retiree.

_____ I wish to cancel my 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