# 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)
☐ 0-9 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. **(please circle one)**

_____ 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. **(please circle one)**

_____ 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 |
|---|
| |