



State of Louisiana
Office of Group Benefits - Flexible Benefits Plan
Request for Change to Flexible Benefits Plan Elections

2016

Please print hard, using a ballpoint pen. Submit this form to your Human Resources/Payroll Office.

Last Name (Print)		First Name		Middle Initial
Home Address		City	State	Zip Code
Home Phone	Social Security Number	Agency Name	Agency Number	Work Phone

Please check the applicable qualifying event. NOTE: Financial hardship is **NOT** an eligible qualifying event. **Required proof** of the qualifying event **must** be attached to this form.

- | | |
|---|---|
| <input type="checkbox"/> Spouse's enrollment
<input type="checkbox"/> Divorce/annulment/legal separation
<input type="checkbox"/> Death of dependent or spouse
<input type="checkbox"/> Birth, adoption, or placement for adoption of dependent
<input type="checkbox"/> Beginning or end of employment of spouse or dependent (including strike or lockout)
<input type="checkbox"/> Change in eligibility/ineligibility of dependent
<input type="checkbox"/> Marriage
<input type="checkbox"/> Change in dependent care cost or provider | <input type="checkbox"/> Change from full-time to part-time employment or vice versa
<input type="checkbox"/> Beginning or returning from FMLA/unpaid leave/military leave
<input type="checkbox"/> Acknowledgement, judgment, decree or order to cease/provide coverage for a dependent or spouse
<input type="checkbox"/> HIPAA Special Enrollment (birth or adoption only)
<input type="checkbox"/> Gain or loss of Medicare or Medicaid eligibility
<input type="checkbox"/> Change in place of residence or workplace (The change must affect eligibility for coverage)
<input type="checkbox"/> Significant increase or decrease in cost or coverage
<input type="checkbox"/> New benefits package option |
|---|---|

This is to certify that I have experienced the qualifying event indicated above, and therefore wish to change my Flexible Benefits Plan elections. I understand that if my request is due to a change in status, the election must be consistent with the qualifying event. Requests for approved changes are on a **prospective** basis.

Employee Signature _____ Date Signed _____

To be completed by Payroll/Human Resources ONLY

Requested Change:

Type	Provider	From Level of Coverage (OLD)	Premium (Deduction)	To Level of Coverage (NEW)	Premium (Deduction)
Life					
Medical					
Miscellaneous					
Miscellaneous					
General-Purpose Health Care FSA					
Limited-Purpose Dental/Vision FSA					
Dependent Care FSA					

Date Form Received by Agency _____ Date Sheltered Premium Amount Changed _____

Effective Date of Coverage Change _____ Date Form Sent to OGB Flexible Benefits Administrator _____

Agency or Payroll Name _____ OGB Agency Number _____

Sent by _____ Phone Number _____