

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

AGENCY NUMBER AGENCY NAME			PRIMA	PRIMARY PLAN PARTICIPANT / EMPLOYEE NAME				DATE OF HIRE		
Section 1 –Prima	ry Plan P	articipant / Emplo	yee l	nformati	on					
NAME (LAST, FIRST, MIDDLE INITIAL)				NAME CHANGE □Y □N	SOCIAL SEC	CURITY NUMBER		DATE OF	BIRTH	
PHYSICAL ADDRESS				CITY	CITY		STATE	ZI	IP CODE	
MAILING ADDRESS (IF DIFFERENT)					CITY			STATE	ZI	IP CODE
HOME PHONE NUMBER		WORK / ALT PHONE NUMBER			EMAIL ADD	DRESS			SEX	
Section 2 –Enroll	ment Info	ormation								
LEVEL OF HEALTH AND			CTION	SEE SECTIC	NS 3 AN	ND 4.				
For each dependent, employee theck the appropriate box of sell Employee Only		ng more than 4 dependents, e		must complet			,	ice, emp	oloyee m	ust also
NAME (LAST, FIRST, MIDDLE IN	, ,	RELATIONSHIP	SEX	<u> </u>		ADD/ DELETE	SOCIAL SECURITY NU	IMBER	HEALTH	DEP. LIFE
SPOUSE			□M □F			□ADD □DELETE			□YES	□YES
DEPENDENT			□M □F			□ADD □DELETE			□YES	□YES
DEPENDENT			□M □F			□ADD □DELETE			□YES	□YES
DEPENDENT			□M □F			□ADD □DELETE			□YES	□YES
DEPENDENT			□M □F			□ADD □DELETE			□YES	□YES
Section 3 -Health	Plan Sel	lection								
OMPLETE THE APPLICA	BLE SECTIO	N BELOW. SELECT ON	LY ONE	HEALTH P	LAN.					
□Pelican HRA 1000 (Admini	stored by Plue	Active Employee					ork - Administered b	v Pluo (Cross)	
☐Magnolia Local Plus (Admi	•			-			Insured by Vantage I	-		O-POS)
☐Magnolia Open Access (Ac☐Pelican HSA 775 (Actives C \$ monthly de	Only -Administe				_		ve/Non-Medicare Re ve/Non-Medicare Re			
		ned if you complete the Health on, the Health Savings Accoun								
		Me	edicare	Retirees						
OGB Secondary Plans: □Pelican HRA 1000 (Admini □Magnolia Local Plus (Admi □Magnolia Open Access (Admini) Optional: Retiree 100 □Employee Only □Depen	inistered by Blu Iministered by	e Cross) Blue Cross)	□Vantag □LSU Fir		me HMO (N or Eligible L	ЛННР) (Insure .SU retirees o	•			S)
□Vantage Medicare Advant □Vantage Medicare Advant □Vantage Medicare Advant □Peoples Health Medicare A □One Exchange (Enrollmen	dents must hav age Premium H age HMO-POS I age Zero Premi Advantage Plan t is conducted t	ve both Medicare A and Medic IMO-POS Plan Plan um Plan]	EMPL □No Cove □Hospital □Medical □Drugs (P	rage (Part A) (Part B) (Part D)	SPOUSE No Coverage Hospital (Part A) Medical (Part B) Drugs (Part D)	HED		



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AGENCY NUMBER	AGENCY NAME	PRIMARY PLAN PARTICIPANT / EMPLOYEE NAME	SOCIAL SECURITY NUMBER

Section 4 –Life and Flexible Benefits Plan Selection

LIFE INSURANCE (check one only)

BASIC	BASIC PLUS SUPPLEMENTAL			
□Employee/No Dependent Coverage □Employee/Dependent Coverage Eligible Spouse \$1000 Eligible Child \$500 □Employee/Dependent Coverage Eligible Spouse \$2000 Eligible Child \$1000	□Employee/No Dependent Coverage □Employee/Dependent Coverage Eligible Spouse \$2000 Eligible Child \$1000 □Employee/Dependent Coverage Eligible Spouse \$4000 Eligible Child \$2000			
Annual Salary Date of Last Salary In	creaseFace Life			

OGB FLEXIBLE BENEFITS (check all that apply)

Flexible Benefits (Actives Only)
☐Decline Flexible Spending Account(s)
☐ 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 Enrollment
Form.

Section 5 –Acknowledge Offer and Decline Health Insurance Coverage

☐ ACKNOWLEDGE OFFER AND DECLINE HEALTH INSURANCE COVERAGE

I have been offered health coverage for me and my eligible dependents. I have voluntarily elected to decline the coverage as indicated below. If I choose to apply for health coverage at a later date, I understand that I may only enroll for health coverage during annual enrollment or as otherwise specified in the OGB health plan document in the event I, or my eligible dependents have a Plan Recognized Qualified Life Event.

Important: The Affordable Care Act requires each individual to have basic health insurance coverage (known as minimum essential coverage), qualify for an exemption, or make a shared responsibility payment when filing his/her federal income tax return. Failure to enroll in an OGB plan or obtain other minimum essential coverage may result in personal financial penalties.

Reason for Declining Health Insurance Offer:

Other Group Health Coverage (would include being covered as a dependent under an OGB plan)

□Other Individual Health Coverage

□Medicare □Medicaid □Other, Explain: _____

 \square I am not enrolled in any health coverage and I do not accept this offer of health coverage.

 \Box I do not wish to disclose.

Agency Representative Signature

NOTE TO AGENCY REPRESENTATIVE: If the employee declines health coverage, he or she must acknowledge the offer of coverage in a method determined by the agency participating employer. The acknowledgment must be retained by the agency participating employer as evidence that the employee was offered health coverage within the timeframes allowed by law and the employee subsequently declined the offer of coverage.

Section 6 – Acknowledgment and Certification

BY SIGNING THIS APPLICATION, I ACKNOWLEDGE AND CERTIFY THE FOLLOWING:

- > I, Primary Plan Participant, acknowledge that I have provided appropriate documents to OGB to verify my eligibility and the eligibility any requested covered dependents 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 or retirement check to pay for insurance for myself and my dependents as 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 this Acknowledgment and Certification will become a part of my application for coverage and that a copy of my signature is as valid as the original.
- ► I acknowledge that any disenrollment from an OGB Plan of Benefits will result in disenrollment from both medical and pharmacy benefits, including, but not limited to, Medicare Part D.

(QLE) for Application (REFERENCE OGB 2016 QLE SPREADSHEET):
QUALIFIED EVENT DATE ADD/DROP/REINSTATE COVERAGE □ ADD □ DROP □ REINSTATE COVERAGE

Date