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

2014

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**.**

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

Revised 7/13 WHITE - AGENCY PAYROLL OFFICE YELLOW - OGB FLEXIBLE BENEFITS PLAN (Fax # 225-925-4860) PINK - EMPLOYEE COPY

Print Form Reset Form