



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

Agency Number, Agency Name, Primary Plan Participant/Employee Name, Date of Hire

Section 1 - Primary Plan Participant/ Employee Information. Fields for Name First, M.I., Last, Social Security Number, Date of Birth, Home Phone number, Work/Alt Phone Number, Email Address*, Gender, Mailing Address, Physical Address.

Section 2 - Rehired Retiree

When a retiree with OGB coverage returns to benefits-eligible employment, the hiring agency must notify OGB within 30 days of reemployment and the hiring agency must begin to pay the employer portion of the Re-employed Retiree premium from the date of hire.

AGENCY RETIRED FROM, RETIREMENT DATE (MM/DD/YYYY)

Section 3 - Enrollment Information

LEVEL OF HEALTH AND LIFE COVERAGE - FOR PLAN SELECTION SEE SECTIONS 4 AND 5

For each dependent, employee must check the box in section 3 if they wish that dependent to have health and/or life coverage. For life insurance, employee must also check the appropriate box of section 5. If adding more than 4 dependents, employee must complete, sign and submit a second GB-01 form.

Employee Only, Employee + Child(ren), Employee + Spouse, Family

Table with columns: NAME, RELATIONSHIP, SEX, BIRTH DATE, ADD/DELETE, SOCIAL SECURITY NUMBER, HEALTH, DEP. LIFE. Rows for SPOUSE and four DEPENDENT entries.

Section 4 - Health Plan Selection

COMPLETE THE APPLICABLE SECTION BELOW. SELECT ONLY ONE HEALTH PLAN.

Active Employees and Non-Medicare Retirees. Options for Pelican HRA1000, Magnolia Local, Magnolia Open Access, Pelican HSA775, LSU First Option 1.

Medicare Retirees

OGB Secondary Plans, OGB Sponsored Medicare Advantage Plans, MEDICARE VERIFICATION table, A COPY OF MEDICARE CARD MUST BE ATTACHED



Agency Number	Agency Name	Primary Plan Participant/Employee Name	Social Security Number
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Section 5 - Life and Flexible Benefits Plan Selection

LIFE INSURANCE (check one only) OGB FLEXIBLE BENEFITS (check all that apply)

DECLINE LIFE INSURANCE COVERAGE

BASIC	BASIC PLUS SUPPLEMENTAL
<input type="checkbox"/> Employee/No Dependent Coverage <input type="checkbox"/> Employee/Dependent Coverage Eligible Spouse \$1,000 Eligible Child \$500 <input type="checkbox"/> Employee/Dependent Coverage Eligible Spouse \$2,000 Eligible Child \$1,000	<input type="checkbox"/> Employee/No Dependent Coverage <input type="checkbox"/> Employee/Dependent Coverage Eligible Spouse \$2,000 Eligible Child \$1,000 <input type="checkbox"/> Employee/Dependent Coverage Eligible Spouse \$4,000 Eligible Child \$2,000

Annual Salary _____ Date of Last Salary Increase _____ Face Life _____

FLEXIBLE BENEFITS (ACTIVE EMPLOYEES ONLY)

Decline flexible spending account
 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 form.

Section 6 - Acknowledge Offer and Decline Health Insurance Coverage (Active Employees Only)

ACKNOWLEDGE OFFER AND DECLINE HEALTH INSURANCE COVERAGE (ACTIVE EMPLOYEES ONLY)

I have been offered health coverage for myself 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 plan document in the event I, or my eligible dependents have a Plan Recognized Qualified Life Event.

Reason for Declining Health Coverage Offer:

- Other Group Health Coverage (would include being covered as a dependent under an OGB plan)
- Other Individual Health Coverage
- Medicare, Medicaid, Other, Explain:
- I am not enrolled in any health coverage and I do not accept this offer of health coverage
- I do not wish to disclose

NOTE TO AGENCY REPRESENTATIVE: If the employee declines health coverage, he or she must acknowledge the offer of coverage by completing the GB-01 form. The acknowledgment must be sent to OGB and a copy retained by the agency participating employer as evidence that the employee was offered health coverage within the time-frames allowed by law and the employee subsequently declined the offer of coverage.

Section 7 - 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 provided appropriate documents to ogb to verify my eligibility and the eligibility of my covered dependent(s) 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, if 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 dis-enrollment from an OGB plan of benefits will result in dis-enrollment from both medical and pharmacy benefits, including, but not limited to, Medicare Part D.

Signature	Date
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FOR AGENCY USE

PLAN RECOGNIZED QUALIFIED LIFE EVENT (QLE) FOR APPLICATION (REFERENCE 2023 QLE SPREADSHEET):

QLE code or qualified life event description	Qualified life event date	Add/Drop/Reinstate Coverage <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Reinstate Coverage
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I, Agency Representative, certify that the documentation presented is appropriate and supports the occurrence of the OGB plan-recognized qualified life event referenced above.

Signature of Agency Representative	Date
Printed Name of Agency Representative	Date