**State of Louisiana**
**Office of Group Benefits - Flexible Benefits Plan**

# Premium Conversion Enrollment/Stop Form

**2015**

***Read this form carefully. You must sign and date this form below to enroll in Premium Conversion or stop participation in the Flexible Benefits Plan.*** Health coverage and insurance providers for participating payroll systems are approved by the state to provide coverage through the Flexible Benefits Plan to state employees on a pre-tax salary deduction basis. **According to IRS rules, not all premiums from providers are allowable for inclusion in the tax-free Flexible Benefits Plan.** If you currently have premiums that are payroll-deducted and want to participate in the Flexible Benefits Plan, **only deductions for premiums allowable by the IRS, and approved for payroll deduction by the state, will be made on a tax-free basis.** All other premiums will continue to be deducted after taxes. (This is **not** an application for health coverage or insurance. You **must** contact the individual provider and complete the necessary forms to enroll.)

| Last Name (Print) | First Name | Middle Initial |
|---|---|---|
| | | |

| Home Address | City | State | Zip Code |
|---|---|---|---|
| | | | |

| Home Phone | Social Security Number | Agency Name | Agency Number | Work Phone |
|---|---|---|---|---|
| | | | | |

**Check one box below for the benefit or action you are requesting:**

☐ **Premium Conversion - Tax-Free Deduction of Eligible Premiums. Enroll me in Premium Conversion.** I want all of my eligible premiums deducted on a TAX-FREE basis. I hereby authorize my employer to reduce my gross salary for each pay period (before federal and state income taxes are calculated) by the total per pay period premium deductions for eligible benefits.

☐ **STOP.** Stop my participation in the Flexible Benefits Plan at the end of this Flexible Benefits plan year. I no longer want any of my eligible benefits deducted on a TAX-FREE basis.

## IMPORTANT: Salary Reduction Agreement

I hereby authorize my employer to reduce my gross salary (before federal and state income taxes are calculated) for each pay period by the total amount of premium deductions for eligible benefits. If applicable, I understand that this salary reduction might produce lower Social Security benefits.

The tax-free deductions of eligible premiums will continue from one plan year to the next plan year until:
(1) I discontinue coverage by placing a check in the STOP box above;
(2) I modify my tax-free deductions for eligible premiums during the Annual Enrollment period; or
(3) I experience an IRS-recognized qualifying event and receive approval to change my deductions.

I understand and agree that my employer and the Flexible Benefits Plan administrator will be held harmless from any liability resulting from either my participation in the Flexible Benefits Plan or my failure to sign or accurately complete this enrollment form.

**Employee Signature** _____ **Date Signed** _____

**Payroll Use ONLY**

Agency or Payroll Name _____ OGB Agency Number _____

Check one : ☐ Annual Enrollment ☐ New Hire ☐ IRS-Recognized Qualified Event

Number of Payroll Periods _____ Hire Date _____

Submitted by _____ Phone Number_____

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