STATE OF LOUISIANA - OFFICE OF GROUP BENEFITS - ENROLLMENT/CHANGE FORM

AGENCY NUMBER	AGENCY NAME	DATE OF HIRE	ANNUAL SALARY	EMPLOYEE NAME CHANGED TO

PURPOSE

☐ Waiver of Coverage ☐ Agency Transfer ☐ New Enrollment ☐ Reinstate Coverage ☐ Re-enrollment - Previous Employment ☐ Rehired Retiree

☐ Annual Enrollment ☐ Add/Delete Dependent(s)_____ (Date) Reason for Addition/Deletion_____

☐ Surviving Spouse/Dependent ☐ Special Enrollment ☐ Late Applicant ☐ Retired _____ (Date)

☐ Employment Terminated _____ (Date) ☐ Deceased _____ (Date)

☐ Cancel all coverage **(health and life)** _____ (Reason for Cancellation) ☐ Other _____

PERSONAL INFORMATION (Please print or type)

NAME (LAST, FIRST, MIDDLE INITIAL)			SOCIAL SECURITY NUMBER		DATE OF BIRTH	
ADDRESS			CITY		STATE	ZIP CODE
PHONE NUMBER ( )	EMAIL ADDRESS	SEX ☐ M ☐ F	MARITAL STATUS ☐ SINGLE ☐ MARRIED	DATE OF MARRIAGE	DATE OF DIVORCE	

HEALTH PLAN SELECTED (Write in health plan selection)

LEVEL OF MEDICAL COVERAGE ☐ No coverage ☐ Employee Only ☐ Employee + Children/Child ☐ Employee + Spouse ☐ Family

NAME (LAST, FIRST, MIDDLE INITIAL)	RELATIONSHIP	SEX	BIRTH DATE (MM/DD/YYYY)	ADD/ DELETE	SOCIAL SECURITY NUMBER	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

RETIREE 100

☐ Employee Only ☐ Dependent Only ☐ Employee + 1 Dependent

C.O.B.R.A.

☐ Prior F/T Terminated ☐ Divorced Spouse ☐ Dependent

MEDICARE

EMPLOYEE	SPOUSE
☐ No Coverage ☐ Hospital (Part A) ☐ Medical (Part B) ☐ Drugs (Part D)	☐ No Coverage ☐ Hospital (Part A) ☐ Medical (Part B) ☐ Drugs (Part D)
A COPY OF MEDICARE CARD MUST BE ATTACHED	

LIFE INSURANCE (check one only)

☐ No Coverage

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 Increase _____ Face Life _____

☐ WAIVER OF COVERAGE

I waive all coverage offered through the Office of Group Benefits. I understand that if I enroll for OGB offered life insurance at a future date, the coverage I receive will be subject to evidence of insurability.

NOTE TO AGENCY REPRESENTATIVE: If the employee waives his/her right to all coverage, he/she must sign an enrollment document. A copy of this document is to be retained by the agency as evidence the employee was offered coverage within 30 days of eligibility and the employee declined. The original of this document is to be transmitted to the Office of Group Benefits.

☐ ACKNOWLEDGEMENT OF COVERAGE LIMITATIONS

- I understand that I must provide appropriate documents to OGB to verify eligibility of all covered dependents. I acknowledge that my application for dependent coverage will not be approved until all required documents are received.
- I acknowledge that I have reviewed the descriptive literature about OGB health plans available to me. I apply for participation or a change in my participation in the named health plan and agree to be bound by its terms and conditions.
- I authorize deductions from my earnings or retirement check to pay for insurance for myself and my dependents, if applicable.
- I certify that the information provided on this form is true and correct. I understand that if I provide false information on this form, it may result in denial or recision of coverage retroactive to the initial day of coverage. A copy of my signature is as valid as the original.
- I accept that this declaration will become a part of my application for coverage.

Employee Signature Date Agency Representative Signature Date