

STATE OF LOUISIANA
OFFICE OF GROUP BENEFITS and
HEALTH MAINTENANCE ORGANIZATION/HMO
ENROLLMENT/CHANGE FORM

Agency Number Agency Name Date of Hire Annual Salary Employee Name changed to:

A. PURPOSE

Waiver of Coverage Agency Transfer (Receiving Agency) New Enrollment Reinstatement Coverage Re-enrollment - Previous Employment Annual Enrollment
Add/Delete Dependent (s) Reason for Addition/Deletion
Surviving Spouse/Dependent Special Enrollment Late Applicant - Portability Law Applies? No Yes Retired
Employment Terminated For gross misconduct Deceased
Cancel all coverage Reason for Cancellation
Primary Care Physician Change Name/Address Change Other

B. PERSONAL INFORMATION - EMPLOYEE (Please print or type)

Last Name, First, MI Name Social Security Number Date of Birth
Address City State Zip Code
Home Phone Work Phone Extension Sex Marital Status Date of Marriage Date of Divorce
1. Male 2. Female 1. Single 2. Married

C. HEALTH PLAN SELECTED:

D. LEVEL OF MEDICAL COVERAGE SELECTED
No Coverage Employee Only Employee + Child/Children Employee + Spouse Family

Table with columns: Name (Last name, first, MI), Relationship, Sex, Birth Date (mm/dd/ccyy), Add/Delete, Social Security Number, Health, Dep. Life, HMO Requirement (Primary Care Physician Name, Previous Patient), HMO Use Only (Physician #)

Are you or family members listed above covered by any other group health insurance/HMO from another employer/organization/Medicaid? No Yes. If Yes provide the following:

Policy Holder's Name Social Security No. Birth Date Policy Number Group Number Coverage Type Effect. Date
Employer/Company Insurance Company/HMO (Name/Address/Phone) Persons covered under other policy

E. COBRA

Prior P/T Terminated Prior F/T Terminated Prior F/T - Part Time Divorced Spouse Continued Dependent

Name of original member

Social Security Number

F. MEDICARE

G. RETIREE 100

I. WAIVER OF COVERAGE

Employee Spouse
1. No Coverage 2. Hospital (Part A) 3. Medical (Part B) 4. Hospital & Medical
1. No Coverage 2. Hospital (Part A) 3. Medical (Part B) 4. Hospital & Medical

H. MENTAL HEALTH RIDER

I waive all coverage under the Office of Group Benefits/HMO and I understand if I enroll at a future date that the coverage will be subject to the evidence of insurability for life insurance and a Pre-Existing Condition (PEC) for health insurance, and may be conditional.
NOTE TO AGENCY REPRESENTATIVE: If employee waives 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 Group Benefits.

A COPY OF MEDICARE CARD MUST BE ATTACHED

EMPLOYEE SIGNATURE

DATE

J. LIFE INSURANCE (Check only one)

No Coverage Employee/Dependent

BASIC

BASIC PLUS SUPPLEMENTAL

Employee/No Dependent Coverage Employee/Dependent Coverage Eligible Spouse \$1,000 Eligible Child \$500
Employee/No Dependent Employee/Dependent Coverage Eligible Spouse \$2,000 Eligible Child \$1,000
Employee/Dependent Coverage Eligible Spouse \$2,000 Eligible Child \$1,000 Employee/Dependent Coverage Eligible Spouse \$4,000 Eligible Child \$2,000

NOTICE: YOU MUST PERSONALLY BEAR ALL COSTS IF YOU UTILIZE HEALTH CARE NOT AUTHORIZED BY THIS PLAN OR PURCHASE DRUGS WHICH ARE NOT AUTHORIZED BY THIS PLAN.

I reviewed the descriptive literature about the Plans available to me. I apply for participation/change 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 dependents, if applicable. I CONSENT TO THE MEDICAL RELEASE AND OTHER ENROLLMENT INFORMATION ON THE BACK OF THIS FORM. I certify that the information provided on this form is true and correct. I understand that if I provide material false information on this form, it may result in denial or rescission of coverage retroactive to the initial day of coverage. A copy of my signature is as valid as the original.

Employee Signature Date

Agency Rep. Date

OFFICE USE ONLY

Life Health E of I Specialist Int. Date

Date of Last Salary Increase Annual Salary Face Life