

# 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   
  Reinstatement Coverage   
  Re-enrollment - Previous Employment   
  Rehired Retiree  
 Annual Enrollment   
  Add/Delete Dependent(s) \_\_\_\_\_ Reason for Addition/Deletion \_\_\_\_\_  
 Surviving Spouse/Dependent   
  Special Enrollment   
  Late Applicant \_\_\_\_\_ Date \_\_\_\_\_   
  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 <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> 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		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> ADD <input type="checkbox"/> DELETE		<input type="checkbox"/> YES	<input type="checkbox"/> YES
DEPENDENT		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> ADD <input type="checkbox"/> DELETE		<input type="checkbox"/> YES	<input type="checkbox"/> YES
DEPENDENT		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> ADD <input type="checkbox"/> DELETE		<input type="checkbox"/> YES	<input type="checkbox"/> YES
DEPENDENT		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> ADD <input type="checkbox"/> DELETE		<input type="checkbox"/> YES	<input type="checkbox"/> YES
DEPENDENT		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> ADD <input type="checkbox"/> DELETE		<input type="checkbox"/> YES	<input type="checkbox"/> 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
<input type="checkbox"/> No Coverage <input type="checkbox"/> Hospital (Part A) <input type="checkbox"/> Medical (Part B) <input type="checkbox"/> Drugs (Part D)	<input type="checkbox"/> No Coverage <input type="checkbox"/> Hospital (Part A) <input type="checkbox"/> Medical (Part B) <input type="checkbox"/> Drugs (Part D)
A COPY OF MEDICARE CARD MUST BE ATTACHED	

## LIFE INSURANCE (check one only)

BASIC	BASIC PLUS SUPPLEMENTAL
<input type="checkbox"/> Employee/No Dependent Coverage <input type="checkbox"/> Employee/Dependent Coverage Eligible Spouse \$1000 Eligible Child \$500 <input type="checkbox"/> Employee/Dependent Coverage Eligible Spouse \$2000 Eligible Child \$1000	<input type="checkbox"/> Employee/No Dependent Coverage <input type="checkbox"/> Employee/Dependent Coverage Eligible Spouse \$2000 Eligible Child \$1000 <input type="checkbox"/> 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 rescission 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