STATE OF LOUISIANA
OFFICE OF GROUP BENEFITS
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 ☐ Reinstate Coverage ☐ Re-enrollment - Previous Employment Rehired Retiree ☐ Yes ☐ No

☐ Annual Enrollment ☐ Add/Delete Dependent (s) ____________ Date Reason for Addition/Deletion ____________

☐ Surviving Spouse/Dependent ☐ Special Enrollment ☐ Late Applicant - Portability Law Applies? ☐ No ☐ Yes ☐ Retired ____________ Date

☐ Employment Terminated ____________ Date ☐ Deceased____________ Date

☐ **Cancel all coverage** (Health & Life) ____________ Reason for Cancellation ☐ Other ____________

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

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

C. HEALTH PLAN SELECTED:

D. LEVEL OF MEDICAL COVERAGE SELECTED

☐ No Coverage ☐ Employee Only ☐ Employee + Child/Children ☐ Employee + Spouse ☐ Family

Name (Last name, first, MI)	Relationship	Sex	Birth Date (mm/dd/ccyy)	Add/Delete	Social Security Number	Health	Dep. Life
Employee		☐ M ☐ F		☐ Add ☐ Delete			
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

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 F/T Terminated ☐ Divorced Spouse ☐ Dependent

____________ Name of original member ____________ Social Security Number

F. MEDICARE

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

A COPY OF MEDICARE CARD MUST BE ATTACHED

G. RETIREE 100

☐ Yes ☐ No ☐ Employee Only
☐ Dependent Only ☐ Employee & 1 Dependent

H. MENTAL HEALTH RIDER

☐ Yes ☐ No

I. LIFE INSURANCE (Check only one)

☐ No Coverage Employee/Dependent

BASIC	BASIC PLUS SUPPLEMENTAL
☐ Employee/No Dependent Coverage	☐ Employee/No Dependent
☐ Employee/Dependent Coverage Eligible Spouse $1,000 Eligible Child $500	☐ 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

Annual Salary ____________

Date of Last Salary Increase ____________

Face Life ____________

SSN ____________________

Medical Release

I authorize health care providers of services to me and my dependents to release information (including information related to diagnosis or treatment of mental health and/or substance abuse problems, or acquired immune deficiency syndrome) to my Office of Group Benefits (OGB) health plan and all participating providers to the extent necessary to determine responsibility for payment of claims and for utilization review and quality assurance purposes. A copy of this authorization is as valid as the original.

I understand that the names of participating providers in my OGB health plan may change during the plan year. The health plan does not guarantee the continuing participation of the named health care providers.

Plan Members With Enrolled Children Please Note:

IF YOU ARE DIVORCED AND HAVE CHILDREN UNDER AGE 18 AND IF A COURT ORDER HAS BEEN ISSUED ASSIGNING FINANCIAL RESPONSIBILITY, YOUR HEALTH PLAN MUST BE PROVIDED WITH A COPY.

IF THE CHILD IS OVER AGE 21, PROOF OF FULL TIME STUDENT STATUS FROM AN ACCREDITED SCHOOL MUST BE PROVIDED TO YOUR HEALTH PLAN AT THE TIME OF INITIAL ENROLLMENT AND AT THE START OF EACH SEMESTER.

New Hires and Acknowledgements

I acknowledge that my application will be approved on a conditional basis.

I understand that unless the Portability Law applies, any illness, injury, disease, or condition for which any treatment was received within the six months prior to the date of application for coverage will have no benefits available for the 12 months following the effective date of application for coverage.

I understand that any disease, illness, accident, or injury will be classified as a pre-existing condition if, during the six-month period preceding the effective date of coverage, any treatment or services were received or drugs were prescribed for such disease, illness, accident, or injury.

The term **Treatment** shall mean all steps taken to effect the cure of a disease, illness, accident, or injury and shall include, but not be limited to, consultations, examinations, diagnosis, and any application of remedies.

I accept the conditional approval for coverage and agree that this declaration will become a part of my application for coverage.

J. WAIVER OF COVERAGE

______ I waive all coverage under the Office of Group Benefits Program/HMO and I understand if I enroll at a future date that the coverage will be subject to 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.

EMPLOYEE SIGNATURE ______________________ DATE ______________

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 it's 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 AS EXPLAINED ABOVE. 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 recision of coverage retroactive to the initial day of coverage. A copy of my signature is as valid as the original.

X ______________________ Employee Signature ______________ Date

______________________ Agency Rep. ______________ Date

OFFICE USE ONLY

_____ Life _____ Health _____ Specialist Int. _____ Date