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 (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 _____

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

HEALTH PLAN SELECTED (Write in health plan selection)

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/yyyy)	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		

C.O.B.R.A.

☐ Prior F/T Terminated ☐ Divorced Spouse ☐ Dependent

_____ (Name of Original Member) _____ (Social Security Number)

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

RETIREE 100

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

LIFE INSURANCE (Check only one)

☐ No Coverage Employee/Dependent

BASIC

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

Date of Last Salary Increase _____

BASIC PLUS SUPPLEMENTAL

☐ Employee/No Dependent
☐ Employee/Dependent Coverage
Eligible Spouse $2,000 Eligible Child $1,000
☐ Employee/Dependent Coverage
Eligible Spouse $4,000 Eligible Child $2,000
Annual Salary _____
Face Life _____

WAIVER OF COVERAGE

I waive all coverage offered through the Office of Group Benefits. I understand that if I enroll at a future date, the coverage I receive will be subject to evidence of insurability for life insurance and a pre-existing condition (PEC) exclusion for health insurance, and may be conditional.

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.

_____ _____

EMPLOYEE SIGNATURE DATE

This plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, consultations, examinations, diagnosis, care, or treatment was recommended or received within the previous 6 months. Generally, this 6-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 6-month period ends on the day before the waiting period begins.

The pre-existing condition exclusion does not apply to pregnancy, or to a child who is enrolled in the plan or enrolled in other creditable coverage within 30 days after birth, adoption, or placement for adoption. Effective July 1, 2011, the pre-existing condition exclusion does not apply to any employee or dependent who is under age 19.

This exclusion may last up to 12 months from your first day of coverage or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior creditable coverage. Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days.

To reduce the 12-month exclusion period by your creditable coverage, you must give OGB a copy of any certificates of creditable coverage (HIPAA certificates) you have. If you do not have a certificate, but you do have prior health coverage, OGB will help you obtain a certificate from your prior plan or issuer. There are also other ways you can show that you have creditable coverage. Contact OGB if you need help demonstrating creditable coverage.

Each HIPAA certificate (or other evidence of creditable coverage) will be reviewed by OGB to determine its authenticity. Submission of a fraudulent HIPAA certificate is considered a federal health care crime under HIPAA and may be punishable by fine and/or imprisonment.

All questions about the pre-existing condition exclusion and creditable coverage should be directed to Office of Group Benefits, Eligibility Department, P. O. Box 66678, Baton Rouge, LA 70896, phone (225) 925-6934 or (toll-free) 1-800-272-8451 or (TDD) 1-800-259-6771 or fax (225) 925-6333.

ACKNOWLEDGMENT OF COVERAGE LIMITATIONS AND PRE-EXISTING CONDITION EXCLUSION

I understand that I must provide appropriate documents to OGB to verify eligibility of all covered dependents. I acknowledge that my application will be approved on a conditional basis.

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

_____ _____

EMPLOYEE SIGNATURE DATE

_____ _____

AGENCY REPRESENTATIVE SIGNATURE DATE

OFFICE USE ONLY Life _____ Health _____ Specialist Int. _____ Date _____