

STATE OF LOUISIANA
OFFICE OF GROUP BENEFITS
ENROLLMENT/CHANGE FORM

Agency Number 2032	Agency Name LPPS	Date of Hire	Annual Salary	Employee Name Changed to:
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PURPOSE

Waiver of Coverage
 Agency Transfer (Receiving Agency)
 New Enrollment
 Reinstatement 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. <input type="checkbox"/> Male 2. <input type="checkbox"/> Female	Marital Status 1. <input type="checkbox"/> Single 2. <input type="checkbox"/> 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	 	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Add <input type="checkbox"/> Delete		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
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

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 FT Terminated
 Divorced Spouse
 Dependent

Name of Original Member _____

Social Security Number _____

MEDICARE

Employee <input type="checkbox"/> 1. No Coverage <input type="checkbox"/> 2. Hospital (Part A) <input type="checkbox"/> 3. Medical (Part B) <input type="checkbox"/> 4. Drugs (Part D)	Spouse <input type="checkbox"/> 1. No Coverage <input type="checkbox"/> 2. Hospital (Part A) <input type="checkbox"/> 3. Medical (Part B) <input type="checkbox"/> 4. Drugs (Part D)
A COPY OF MEDICARE CARD MUST BE ATTACHED	
RETIREE 100 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Employee Only <input type="checkbox"/> Dependent Only <input type="checkbox"/> Employee & 1 Dependent	

LIFE INSURANCE (Check only one)

No Coverage Employee/Dependent

BASIC <input type="checkbox"/> Employee/No Dependent Coverage <input type="checkbox"/> Employee/Dependent Coverage Eligible Spouse \$1,000 Eligible Child \$500 <input type="checkbox"/> Employee/Dependent Coverage Eligible Spouse \$2,000 Eligible Child \$1,000	BASIC PLUS SUPPLEMENTAL <input type="checkbox"/> Employee/No Dependent <input type="checkbox"/> Employee/Dependent Coverage Eligible Spouse \$2,000 Eligible Child \$1,000 <input type="checkbox"/> Employee/Dependent Coverage Eligible Spouse \$4,000 Eligible Child \$2,000
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Date of Last Salary Increase _____ 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 rescission 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