

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

OPEN ENROLLMENT DOCUMENT

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

Waiver of Coverage
 Agency Transfer (Receiving Agency)
 New Enrollment
 Reinstatement Coverage
 Re-enrollment - Previous Employment
 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 _____
 For gross misconduct
 Deceased _____ Date _____
 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		Social Security Number		Date of Birth	
Name		City		State	Zip Code
Address		Sex		Marital Status	Date of Marriage
Home Phone	Work Phone	Extension	1. <input type="checkbox"/> Male 2. <input type="checkbox"/> Female	1. <input type="checkbox"/> Single 2. <input type="checkbox"/> Married	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)	Relation-ship	Sex	Birth Date (mm/dd/ccyy)	Add/Delete	Social Security Number	Health	Dep. Life	HMO Requirement		HMO Use On
								Primary Care Physician Name	Previous Patient	Physician #
Employee	<input checked="" type="checkbox"/>	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Add <input type="checkbox"/> Delete		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/> No <input type="checkbox"/> Yes	
Spouse	<input checked="" type="checkbox"/>	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Add <input type="checkbox"/> Delete		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> No <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"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> No <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"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> No <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"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> No <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"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> No <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.
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

Employee	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. Hospital & Medical	<input type="checkbox"/> 1. No Coverage <input type="checkbox"/> 2. Hospital (Part A) <input type="checkbox"/> 3. Medical (Part B) <input type="checkbox"/> 4. Hospital & Medical

G. RETIREE 100

Yes
 No
 Employee Only
 Dependent Only
 Employee & 1 Dependent

H. MENTAL HEALTH RIDER

Yes No

I. WAIVER OF COVERAGE

_____ 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 based 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.

EMPLOYEE SIGNATURE

DATE

J. 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

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

Date of
Last Salary Increase _____

Annual Salary _____
Face Life _____

OFFICE USE ONLY

Life Health E of I Specialist Int. Date

X

Employee Signature _____ Date _____

Agency Rep. _____ Date _____

Medical Release

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 HMO or Office of Group Benefits and all participating providers to the extent necessary to determine eligibility 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 HMO or PPO (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 YOUR 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 effective date of coverage will have no benefits available for the 12 months following the effective date of 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.

My 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.