



|               |             |  |              |
|---------------|-------------|--|--------------|
| Agency Number | Agency Name | Primary Plan Participant/Employee Name | Date of Hire |
|---------------|-------------|--|--------------|

**Section 1 - Primary Plan Participant/ Employee Information**

|                                      |                       |                                     |                        |   |
|--------------------------------------|-----------------------|-------------------------------------|------------------------|---|
| Name First                           | M.I.                  | Last                                | Social Security Number | Date of Birth   |
| Home Phone number                    | Work/Alt Phone Number | Email Address* (See footnote below) |                        | Gender<br><input type="checkbox"/> Male <input type="checkbox"/> Female |
| Mailing Address (Street or P.O. Box) | City                  | State                               | Zip Code               | Country   |
| Physical Address (street)            | City                  | State                               | Zip Code               | Country   |

**Section 2 - Rehired Retiree**

When a retiree with OGB coverage returns to benefit-eligible employment the hiring agency must notify OGB within 30 days of reemployment and the hiring agency must begin to pay the employer portion of the premium. Upon returning to retirement, premiums will revert back to the retirement rates and the original retiring agency will resume payment of the employer portion of the premium. Retirees who took their OGB health coverage into retirements MAY NOT waive coverage when returning to work as a full-time employee.

|                     |                              |
|---------------------|------------------------------|
| AGENCY RETIRED FROM | RETIREMENT DATE (MM/DD/YYYY) |
|---------------------|------------------------------|

**Section 3 - Enrollment Information**

**LEVEL OF HEALTH AND LIFE COVERAGE - FOR PLAN SELECTION SEE SECTIONS 3 AND 4**

For each dependent, employee must check the box in section 3 if they wish that dependent to have health and/or life coverage. For life insurance, employee must also check the appropriate box of section 4. If adding more than 4 dependents, employee must complete, sign and submit a second GB-01 form.

- Employee Only    Employee + Child(ren)    Employee + Spouse    Family

| NAME<br>(LAST, FIRST, MIDDLE INITIAL) | RELATIONSHIP | SEX  | BIRTH DATE<br>(MM/DD/YYYY) | ADD/DE-LETE   | SOCIAL SECURITY NUMBER | HEALTH                       | DEP. LIFE                    |
|---------------------------------------|--------------|--|----------------------------|---|------------------------|------------------------------|------------------------------|
| SPOUSE                                |              | <input type="checkbox"/> M<br><input type="checkbox"/> F |                            | <input type="checkbox"/> ADD<br><input type="checkbox"/> DELETE |                        | <input type="checkbox"/> YES | <input type="checkbox"/> YES |
| DEPENDENT                             |              | <input type="checkbox"/> M<br><input type="checkbox"/> F |                            | <input type="checkbox"/> ADD<br><input type="checkbox"/> DELETE |                        | <input type="checkbox"/> YES | <input type="checkbox"/> YES |
| DEPENDENT                             |              | <input type="checkbox"/> M<br><input type="checkbox"/> F |                            | <input type="checkbox"/> ADD<br><input type="checkbox"/> DELETE |                        | <input type="checkbox"/> YES | <input type="checkbox"/> YES |
| DEPENDENT                             |              | <input type="checkbox"/> M<br><input type="checkbox"/> F |                            | <input type="checkbox"/> ADD<br><input type="checkbox"/> DELETE |                        | <input type="checkbox"/> YES | <input type="checkbox"/> YES |
| DEPENDENT                             |              | <input type="checkbox"/> M<br><input type="checkbox"/> F |                            | <input type="checkbox"/> ADD<br><input type="checkbox"/> DELETE |                        | <input type="checkbox"/> YES | <input type="checkbox"/> YES |

**Section 4 - Health Plan Selection**

COMPLETE THE APPLICABLE SECTION BELOW. SELECT ONLY ONE HEALTH PLAN.

**Active Employees and Non-Medicare Retirees**

- Pelican HRA1000 (Administered by Blue Cross)    Magnolia Local (Limited Provider Network - Administered by Blue Cross)  
 Magnolia Local Plus (Administered by Blue Cross)    Vantage Medical Home HMO (MHHP) (Insured by Vantage Health Plan) (HMO-POS)  
 Magnolia Open Access (Administered by Blue Cross)    LSU First Option 1 (for eligible LSU Active Employees/ Non-Medicare Retirees only)  
 Pelican HSA775\* (Actives Only - Administered by Blue Cross)

\$\_\_\_\_\_ monthly deduction

**\*If you select the Pelican HSA775 plan, you must complete the GB-79 form to open a Health Savings Account in your name with a minimum deposit of \$200 provided.**

**Tax implications may apply for certain members.**

**Medicare Retirees**

**OGB Secondary Plans:**

- Pelican HRA1000 (Administered by Blue Cross)    Magnolia Local (Limited Provider Network - Administered by Blue Cross)  
 Magnolia Local Plus (Administered by Blue Cross)    Vantage Medical Home HMO (MHHP) (Insured by Vantage Health Plan) (HMO-POS)  
 Magnolia Open Access (Administered by Blue Cross)    LSU First Option 3 (for eligible LSU Retirees only)

Optional: Retiree 100

- Employee Only    Dependent Only    Employee + 1 Dependent

**OGB Sponsored Medicare Advantage Plans:**

- Vantage Medicare Advantage Premium HMO-POS Plan  
Vantage Medicare Advantage Standard HMO-POS Plan  
Vantage Medicare Advantage Basic HMO-POS Plan  
Peoples Health Medicare Advantage Plan  
Blue Advantage HMO

Humana Medicare Advantage Employer HMO Plan

Via Benefits (Please call 1-855-663-4228 or visit my.ViaBenefits.com/ogb to enroll.)

| MEDICARE VERIFICATION                           |  |
|---|--|
| <input type="checkbox"/> No Coverage            | <input type="checkbox"/> No Coverage       |
| <input type="checkbox"/> Hospital (Part A)      | <input type="checkbox"/> Hospital (Part A) |
| <input type="checkbox"/> Medical (Part B)       | <input type="checkbox"/> Medical (Part B)  |
| <input type="checkbox"/> Drugs (Part D)         | <input type="checkbox"/> Drugs (Part D)    |
| <b>A COPY OF MEDICARE CARD MUST BE ATTACHED</b> |  |

**\*Note to FSA Enrollees:** By providing an email address, you may receive certain benefits-related correspondence through email unless you contact Discovery Benefits, Inc., LLC to receive paper notices. You are responsible to provide us with your current email address and to promptly notify us of any changes to your email address by calling customer service at 1-800-272-8451.



|               |             |  |                        |
|---------------|-------------|--|------------------------|
| Agency Number | Agency Name | Primary Plan Participant/Employee Name | Social Security Number |
|---------------|-------------|--|------------------------|

**Section 5 - Life and Flexible Benefits Plan Selection**

LIFE INSURANCE (check one only) OGB FLEXIBLE BENEFITS (check all that apply)

**DECLINE LIFE INSURANCE COVERAGE**

| BASIC   | BASIC PLUS SUPPLEMENTAL   | FLEXIBLE BENEFITS (ACTIVE EMPLOYEES ONLY)   |
|---|---|---|
| <input type="checkbox"/> Employee/No Dependent Coverage<br><input type="checkbox"/> Employee/Dependent Coverage<br>Eligible Spouse \$1,000 Eligible Child \$500<br><input type="checkbox"/> Employee/Dependent Coverage<br>Eligible Spouse \$2,000 Eligible Child \$1,000 | <input type="checkbox"/> Employee/No Dependent Coverage<br><input type="checkbox"/> Employee/Dependent Coverage<br>Eligible Spouse \$2,000 Eligible Child \$1,000<br><input type="checkbox"/> Employee/Dependent Coverage<br>Eligible Spouse \$4,000 Eligible Child \$2,000 | <input type="checkbox"/> Decline Flexible Spending Account<br><input type="checkbox"/> My Agency Does Not Participate in OGB's Flexible Benefits Plan<br>I Do Want to Participate and Acknowledge That I Have<br><input type="checkbox"/> Completed the Flexible Spending Arrangement Form. |
| Annual Salary _____ Date of Last Salary Increase _____ Face Life _____  |   |   |

**Section 6 - Acknowledge Offer and Decline Health Insurance Coverage (Active Employees Only)**

**ACKNOWLEDGE OFFER AND DECLINE HEALTH INSURANCE COVERAGE (ACTIVE EMPLOYEES ONLY)**

I have been offered health coverage for myself and my eligible dependents. I have voluntarily elected to decline the coverage as indicated below. If I choose to apply for health coverage at a later date, I understand that I may only enroll for health coverage during annual enrollment or as otherwise specified in the OGB plan document in the event I, or my eligible dependents have a Plan Recognized Qualified Life Event.

**Reason for Declining Health Coverage Offer:**

- Other Group Health Coverage (would include being covered as a dependent under an OGB plan)
- Other Individual Health Coverage
- Medicare, Medicaid, Other, Explain:
- I am not enrolled in any health coverage and I do not accept this offer of health coverage
- I do not wish to disclose

**NOTE TO AGENCY REPRESENTATIVE:** If the employee declines health coverage, he or she must acknowledge the offer of coverage by completing the GB-01 form. The acknowledgment must be sent to OGB and a copy retained by the agency participating employer as evidence that the employee was offered health coverage within the time-frames allowed by law and the employee subsequently declined the offer of coverage.

**Section 7 - Acknowledgment and Certification**

**BY SIGNING THIS APPLICATION, I ACKNOWLEDGE AND CERTIFY THE FOLLOWING:**

- (please check each box)*
- I, Primary Plan Participant, acknowledge that I have provided appropriate documents to ogb to verify my eligibility and the eligibility of my covered dependent(s) and those documents are included with this application.
  - I apply for participation or a change in my participation in the named plan(s) and agree to be bound by the plan's terms and conditions.
  - I acknowledge and authorize deductions from my earnings to retirement check to pay for insurance for myself and my dependents, if applicable.
  - I acknowledge and certify that the information provided on this form is true and correct I understand that if I provide false, misleading or incomplete information on this form, it may result in denial or rescission of coverage retroactive to the initial day of coverage.
  - I accept that this acknowledgment and certification will become a part of my application for coverage and that a copy of my signature is as valid as the original.
  - I acknowledge that any dis-enrollment from an OGB plan of benefits will result in dis-enrollment from both medical and pharmacy benefits, including, but not limited to, Medicare Part D.

|           |      |
|-----------|------|
| Signature | Date |
|-----------|------|

**FOR AGENCY USE**

**PLAN RECOGNIZED QUALIFIED LIFE EVENT (QLE) FOR APPLICATION (REFERENCE 2019 QLE SPREADSHEET):**

|  |                           |   |
|--|---------------------------|---|
| QLE code or qualified life event description | Qualified life event date | Add/Drop/Reinstate Coverage<br><input type="checkbox"/> Add<br><input type="checkbox"/> Drop<br><input type="checkbox"/> Reinstate Coverage |
|--|---------------------------|---|

I, Agency Representative, certify that the documentation presented is appropriate and supports the occurrence of the OGB plan-recognized qualified life event referenced above.

|                                       |      |
|---------------------------------------|------|
| Signature of Agency Representative    | Date |
| Printed Name of Agency Representative | Date |