GB-01
7/01

STATE OF LOUISIANA
OFFICE OF GROUP BENEFITS and
HEALTH MAINTENANCE ORGANIZATION/HMO
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 ☐ 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

Name	Social Security Number	Date of Birth	
Address	City	State	Zip Code

Home Phone	Work Phone	Extension	Sex	Marital Status	Date of Marriage	Date of Divorce
( )	( )		1. ☐ Male 2. ☐ Female	1. ☐ Single 2. ☐ Married		

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: Primary Care Physician Name	HMO Requirement: Previous Patient	HMO Use Only: Physician #
Employee		☐ M ☐ F		☐ Add ☐ Delete					☐ No ☐ Yes	
Spouse		☐ M ☐ F		☐ Add ☐ Delete		☐ Yes	☐ Yes		☐ No ☐ Yes	
Dependent		☐ M ☐ F		☐ Add ☐ Delete		☐ Yes	☐ Yes		☐ No ☐ Yes	
Dependent		☐ M ☐ F		☐ Add ☐ Delete		☐ Yes	☐ Yes		☐ No ☐ Yes	
Dependent		☐ M ☐ F		☐ Add ☐ Delete		☐ Yes	☐ Yes		☐ No ☐ Yes	
Dependent		☐ M ☐ F		☐ Add ☐ Delete		☐ Yes	☐ Yes		☐ No ☐ 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 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
☐ 1. No Coverage	☐ 1. No Coverage
☐ 2. Hospital (Part A)	☐ 2. Hospital (Part A)
☐ 3. Medical (Part B)	☐ 3. Medical (Part B)
☐ 4. Hospital & Medical	☐ 4. Hospital & Medical

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

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 ON THE BACK OF THIS FORM. 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 E of I Specialist Int. Date

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 subject 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 _____