LSU Baton Rouge Paid Campuses
Retiree Eligibility and Continuation of Coverage

Under the OGB Administrative Code Title 32, in order to continue health insurance coverage as a retiree under the State of Louisiana the employee must satisfy the following categories:

1. Immediately receive a retirement plan distribution from an approved state or governmental agency defined benefit plan;
2. was not eligible to participate in such a plan or legally opted not to participate in such a plan and either
    - Began employment prior to September 15, 1979, has 10 years of continuous state service, and has reached the age of 65;
    - Began employment prior to September 15, 1979, has 10 years of continuous state services, and has reached the age of 70;
    - Began employment after July 8, 1992, has 10 years of continuous state service, has a credit for a minimum of 40 quarters in the Social Security system at the time of employment, and has reached the age of 65; or
    - Maintained continuous coverage with an OGB plan of benefits as an eligible dependent until he/she became eligible to receive a retirement plan distribution from an approved state governmental agency defined benefit plan as a former state employee; or
3. Immediately received a retirement plan distribution from a state-approved or state governmental agency approved defined contribution plan and has accumulated the total number of years of creditable services which would have entitled him/her to receive a retirement plan distribution from the defined benefit plan of the retirement system for which the employee would have otherwise been eligible.
4. Continued coverage through provisions of COBRA immediately prior to the date of retirement and qualified for any of the Paragraphs 1, 2 or 3.

Premium determination for Retiree health coverage are determined based House Bill 1492, enacted in the 2001 Louisiana State Legislative Session, which implemented a vesting schedule for determining the percentage of state subsidy of medical insurance premiums for retirees, surviving spouses, and surviving dependents. The percentages are based on the number of years an employee participated in a Group Benefits Program, such as PPO, EPO, or HMO.

Vesting Schedule	
Years of coverage	% of subsidy
10 years or fewer	19
More than 10 years but fewer than 15 years	38
More than 15 years but fewer than 20 years	56
20 years or more	75

Please note that if you retire under the Hazardous Duty Plan or have purchased “Air Time” for retirement eligibility under LASERS retirement, you may have additional provisions to determine medical premiums under Act 332 or Act 992. If you fall under these provisions, please contact your Human Resources Office for more information.

_____ I understand the provisions of retiree eligibility and premiums and wish to continue health coverage as a retiree.

_____ I wish to cancel my coverage due to retirement and understand that I will not be able to re-enroll in the future.

Print Name Signature Date

STATE OF LOUISIANA - OFFICE OF GROUP BENEFITS - ENROLLMENT/CHANGE FORM (Page 1 of 2)

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 ☐ Male ☐ Female

Mailing Address (Street or P.O. Box)	City	State	Zip Code	Country

Physical Address (street)	City	State	Zip Code	Country

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)

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 (LAST, FIRST, MIDDLE INITIAL)	RELATIONSHIP	SEX	BIRTH DATE (MM/DD/YYYY)	ADD/DELETE	SOCIAL SECURITY NUMBER	HEALTH	DEP. LIFE
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

Section 4 - Health Plan Selection

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

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

***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.**

OGB Secondary Plans:

☐ Pelican HRA1000 (Administered by Blue Cross)
☐ Magnolia Local Plus (Administered by Blue Cross)
☐ Magnolia Open Access (Administered by Blue Cross)
Optional: Retiree 100
☐ Employee Only ☐ Dependent Only ☐ Employee + 1 Dependent
☐ Magnolia Local (Limited Provider Network - Administered by Blue Cross)
☐ Vantage Medical Home HMO (MHHP) (Insured by Vantage Health Plan) (HMO-POS)
☐ LSU First Option 3 (for eligible LSU Retirees only)

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	
☐ No Coverage ☐ Hospital (Part A) ☐ Medical (Part B) ☐ Drugs (Part D)	☐ No Coverage ☐ Hospital (Part A) ☐ Medical (Part B) ☐ Drugs (Part D)
A COPY OF MEDICARE CARD MUST BE ATTACHED	

***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- Continue Completing for on page 2

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

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)
☐ 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	☐ Employee/No Dependent Coverage ☐ Employee/Dependent Coverage Eligible Spouse $2,000 Eligible Child $1,000 ☐ Employee/Dependent Coverage Eligible Spouse $4,000 Eligible Child $2,000	☐ Decline Flexible Spending Account ☐ My Agency Does Not Participate in OGB's Flexible Benefits Plan I Do Want to Participate and Acknowledge That I Have ☐ Completed the Flexible Spending Arrangement Form.
Annual Salary _____ Date of Last Salary Increase _____ Face Life _____		

☐ **ACKNOWLEDGE OFFER AND DECLINE HEALTH INSURANCE COVERAGE**

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.

Important: The Affordable Care Act requires each individual to have basic health insurance coverage (known as minimum essential coverage), qualify for an exemption, or make a shared responsibility when filing his/her federal income tax return. Failure to enroll in an OGB plan or obtain other minimum essential coverage may result in personal financial penalties.

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
		☐ Add ☐ Drop ☐ 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