GB-01
7/01

STATE OF LOUISIANA
STATE EMPLOYEES GROUP BENEFITS PROGRAM 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)

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

Home Phone ( )	Work Phone ( )	Extension	Sex 1. ☐ Male 2. ☐ Female	Marital Status 1. ☐ Single 2. ☐ Married	Date of Marriage	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)	Relationship	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		☐ No ☐ Yes	
Dependent		☐ M ☐ F		☐ Add ☐ Delete			Yes		☐ No ☐ Yes	
Dependent		☐ M ☐ F		☐			☐ Yes		☐ No ☐ Yes	
Dependent		☐ M ☐ F				☐ Yes	☐ Yes		☐ No ☐ Yes	
Dependent		☐ M ☐ F				☐ Yes	☐ Yes		☐ No ☐ Yes	

Are you or family members listed above covered [illegible] **from another employer/organization/Medicaid? ☐ No ☐ Yes. If Yes provide the following:**

Policy Holder's Name	[illegible]irth Date	Policy Number	Group Number	Coverage Type	Effect. Date

Employer/Company	[illegible]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 Enrollee _____ - _____ 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 F of I Specialist Int. Date

I. WAIVER OF COVERAGE

I waive all coverage under the State Group Benefits Program/HMO and I understand if I enroll at a future date that the coverage will be subject to 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 _____

WHITE- GROUP BENEFITS CANARY - HMO PINK - AGENCY GOLDENROD - PLAN MEMBER

Medical Release

I 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 State Employees Group Benefits Program and all participating providers to the extent necessary to determine responsibility 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 THE 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.

The 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.