

OFFICE OF GROUP BENEFITS  
2019 ANNUAL ENROLLMENT FORM  
Non-Medicare Retirees and Rehired Retirees  
( Please PRINT Clearly )

Plan Member's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, ZIP: \_\_\_\_\_

SSN: \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

NO ACTION IS NECESSARY IF YOU DO NOT WISH TO MAKE A CHANGE  
PLEASE MARK ONE AND ONLY ONE SELECTION BY PLACING AN (X) IN THE APPROPRIATE BOX

**Pelican HRA1000**  
*Administered by Blue Cross*

**Vantage Medical Home Health  
HMO (MHHP)**  
*Insured by Vantage Health*

**Magnolia Local Plus**  
*Administered by Blue Cross*

**Magnolia Open Access**  
*Administered by Blue Cross*

**Magnolia Local (Limited In-Network Provider  
Network)** *Administered by Blue Cross*

PLEASE MAIL OR FAX THIS FORM TO OGB BY NOVEMBER 15, 2018.

**By Mail:** Office of Group Benefits  
Annual Enrollment  
P.O. Box 44036  
Baton Rouge, LA 70804

**By Fax:** Office of Group Benefits  
Annual Enrollment  
(225) 342-9917  
or  
(225) 342-9919

\_\_\_\_\_  
**Plan Member's Signature** (required)

\_\_\_\_\_  
**Date**