

OFFICE OF GROUP BENEFITS
2020 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

R **Pelican HRA1000**
Administered by Blue Cross

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

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

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

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

PLEASE MAIL OR FAX THIS FORM TO OGB BY NOVEMBER 15, 2020.

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