OFFICE OF GROUP BENEFITS

2017 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

☐ 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*

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

PLEASE MAIL OR FAX THIS FORM TO OGB BY NOVEMBER 15, 2016.

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**