OFFICE OF GROUP BENEFITS

2024 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*

PLEASE MAIL OR FAX THIS FORM TO OGB BY NOVEMBER 15, 2023.

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**

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