

OFFICE OF GROUP BENEFITS
2026 ANNUAL ENROLLMENT FORM
Non-Medicare Retirees
(Please PRINT Clearly)

Plan Member's Name: _____

Address: _____

City, State, ZIP: _____

SSN: _____ Phone: (_____) _____

Personal Email Address: _____

NO ACTION IS NECESSARY IF YOU DO NOT WISH TO MAKE A CHANGE.

**IF YOU WISH TO MAKE A CHANGE, PLEASE MARK ONE AND ONLY ONE SELECTION
BY PLACING AN (X) IN THE APPROPRIATE BOX**

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Pelican HRA1000
Administered by Blue Cross

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Magnolia Local Plus
Administered by Blue Cross

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Magnolia Open Access
Administered by Blue Cross

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

PLEASE MAIL, FAX OR EMAIL THIS FORM TO OGB BY NOVEMBER 15, 2025.

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

By Email: OGB.CustomerService@la.gov

Plan Member's Signature *(required)*

Date

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