PLAQUEMINES PARISH GOVERNMENT

2026 Open Enrollment Application & Change Form (PLEASE PRINT CLEARLY)

Name: _____
First **Middle** **Last**

Home Phone Number: _____ **Mobile:** _____

Date of Birth: _____
Month / Date / Year

Plaquemines Parish Government Benefit elections are effective January 1, 2026 to December 31, 2026 for all eligible **active** employees.

2026 Benefit Options – 24 pay periods:

Benefit Plan	*Monthly*	*Bi-weekly*	*Election Status*
Medical (BCBS Option 1) HMO Copay 80 $750D ☐ Employee Only ☐ Employee + 1 ☐ Employee + Family	$ 225.24 $ 473.01 $ 680.24	$ 112.62 $ 236.51 $ 340.12	☐ ADD COVERAGE ☐ CHANGE COVERAGE ☐ DECLINE COVERAGE
Medical (BCBS Option 2) Premier Blue 80/60 $750D ☐ Employee Only ☐ Employee + 1 ☐ Employee + Family	$ 413.90 $ 869.16 $ 1,249.98	$ 206.95 $ 434.58 $ 624.99	☐ ADD COVERAGE ☐ CHANGE COVERAGE ☐ DECLINE COVERAGE
Medical (BCBS Option 3) Blue Saver 80/60 $4000 ☐ Employee Only ☐ Employee + 1 ☐ Employee + Family	$ 129.89 $ 334.90 $ 481.62	$ 64.95 $ 167.45 $ 240.81	☐ ADD COVERAGE ☐ CHANGE COVERAGE ☐ DECLINE COVERAGE
Medical (BCBS Option 4) Blue Connect Copay 100/70C (Ochsner) ☐ Employee Only ☐ Employee + 1 ☐ Employee + Family	$ 329.53 $ 692.01 $ 995.19	$ 164.77 $ 346.01 $ 497.59	☐ ADD COVERAGE ☐ CHANGE COVERAGE ☐ DECLINE COVERAGE
Dental (BCBS) - $1,000 Annual Max ☐ Employee Only ☐ Employee + Family	$ 5.13 $ 12.30	$ 2.57 $ 6.15	☐ ADD COVERAGE ☐ CHANGE COVERAGE ☐ DECLINE COVERAGE
Vision (BCBS) ☐ Employee Only ☐ Employee + Family	$ 1.00 $ 2.37	$ 0.50 $ 1.19	☐ ADD COVERAGE ☐ CHANGE COVERAGE ☐ DECLINE COVERAGE
Life & AD&D ☐ Employee Only ($20,000 Life & AD&D) ☐ Employee + Family (Spouse - $10,000) (Child - $5,000)	$ 5.51 $ 5.80	$ 2.75 $ 2.90	☐ ADD COVERAGE ☐ CHANGE COVERAGE ☐ DECLINE COVERAGE

Dependent Information: Please provide the following information for each family member you wish to enroll for Medical.
For each family member that you are declining coverage complete the "Declination of Health Coverage" Section: This is to certify the available coverage has been explained to me. I have been given the opportunity to apply for the coverage offered to me and my eligible dependents and have voluntarily elected to decline the coverage.

Dependent's Full Name First Middle, Last	Relationship	M/F	Date of Birth	Social Security Number	Declination of Health
SPOUSE	☐ HUSBAND ☐ WIFE				Reason for Declining ☐ Other Group coverage ☐ Medicare ☐ Medicaid ☐ Other, Explain:_____
CHILD	☐ DAUGHTER ☐ SON ☐ STEPDAUGHTER ☐ STEPSON ☐ HANDICAPPED CHILD 25+ ☐ OTHER_____				Reason for Declining ☐ Other Group coverage ☐ Medicare ☐ Medicaid ☐ Other, Explain:_
CHILD	☐ DAUGHTER ☐ SON ☐ STEPDAUGHTER ☐ STEPSON ☐ HANDICAPPED CHILD 25+ ☐ OTHER_____				Reason for Declining ☐ Other Group coverage ☐ Medicare ☐ Medicaid ☐ Other, Explain:_____

CHILD	☐ DAUGHTER ☐ SON ☐ STEPDAUGHTER ☐ STEPSON ☐ HANDICAPPED CHILD 25+ ☐ OTHER_____				Reason for Declining ☐ Other Group coverage ☐Medicare ☐ Medicaid ☐ Other, Explain:_____

PLEASE READ AND SIGN ON THE FOLLOWING PAGE FOR PRE-TAX PREMIUM DEDUCTIONS!!

2026 Beneficiary Designation for Basic Life & AD&D

(If more than one beneficiary is named the beneficiaries shall share equally unless otherwise stated below.)

Last Name Primary / Contingent	**First Name**	**MI**	**Date of Birth**	**Relationship to Insured**

Plaquemines Parish Government's CAFETERIA PLAN

Coverage for the period beginning January 01, 2026 and ending December 31, 2026

ELECTION OF BENEFITS

☐ I elect to pay my required contributions for health and/or dental coverage on a pre-tax basis under Plaquemines Parish Government. I understand my salary will be reduced by an equal amount each pay period to cover the cost of my required contributions during the plan year. This election replaces any prior election(s) I have made.

☐ I have been provided with a schedule of required contributions.

☐ I understand that except for a Change in Status for the applicable coverage under the Plan, I cannot change my benefits election until the next Annual Enrollment period.

AGREEMENT

I agree that my salary will be reduced by the amount of my selected contribution for health benefits under the Plan. I also agree that my salary reductions will continue for each pay period until this election is changed or terminated.

I further understand that:

- *I cannot change or revoke my election prior to the next Annual Enrollment period, unless I experience a Change in Status as defined in the Plan (e.g., birth of a child, divorce, marriage, etc.), and my election change (or revocation) is on account of and is consistent with the Change in Status, as described in the Plan.*
- *Change of status enrollment request must be made within 30 days of the birth, marriage, adoption, etc. and I must complete any separate health insurance enrollment form(s) provided by the insurer(s).*
- *Under current law, salary reduction contributions are not counted when determining FICA earnings. If an employee earns less than the Social Security base wage, his/her final Social Security benefits could be slightly reduced. The value of income and FICA tax savings will normally exceed any final reduction in Social Security*

I have read and agree to the terms in this Agreement and in the Plaquemines Parish Government's Cafeteria Plan.

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Employee's Signature | Employee's last 4 digits Social | Date

IF EMPLOYEE IS DECLINING MEDICAL COVERAGE: Please read and sign.

I acknowledge that I have been given the opportunity to apply for this coverage, which will begin on January 01, 2026 and will end on December 31, 2026. However, if I am NOT electing to enroll in the group medical plan, my reason is as follows:

☐Spousal Coverage ☐Individual Policy ☐Medicaid ☐Medicare ☐VA or Military Insurance ☐ Other (Please Explain)_

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Employee's Signature | Employee's last 4 digits Social | Date