STATE OF LOUISIANA - OFFICE OF GROUP BENEFITS
PARTICIPATION RESEARCH REQUEST

If you disagree with the participation statement the Office of Group Benefits (OGB) provided to you and your human resources department, you may provide evidence of the number of years you participated[1] in an OGB-offered health plan. If that information is not available, you may request that OGB research your participation further.

Please fill out the form below and return to OGB at:

Office of Group Benefits
Attention: Eligibility
P.O. Box 44036
Baton Rouge, LA 70804-4036
Fax: 225-342-9919

PERSONAL INFORMATION (Please print or type)

NAME (LAST, FIRST, MIDDLE INITIAL)		SOCIAL SECURITY NUMBER	DATE OF BIRTH	
ADDRESS		CITY	STATE	ZIP CODE
PHONE NUMBER ( )	EMAIL ADDRESS			

MEMBER COVERAGE (Please print or type)

Fill out this section with the name(s) of your employing agency, the dates you were employed there, and the date(s) you participated in an OGB-offered health plan.

AGENCY NAME	EMPLOYMENT START DATE (MM/DD/YYYY)	EMPLOYMENT END DATE (MM/DD/YYYY)	COVERAGE START DATE (MM/DD/YYYY)	COVERAGE END DATE (MM/DD/YYYY)

SPOUSAL COVERAGE (Please print or type)

If you were covered as a dependent on your spouse's OGB-Offered health plan, please fill out this section with the name(s) of your spouse's employing agency and the date(s) you were covered as a dependent in an OGB-offered health plan.

AGENCY NAME	EMPLOYMENT START DATE (MM/DD/YYYY)	EMPLOYMENT END DATE (MM/DD/YYYY)	COVERAGE START DATE (MM/DD/YYYY)	COVERAGE END DATE (MM/DD/YYYY)

Employee Signature Date

[1]Participation is determined by the number of years you have been enrolled, as the primary plan member or as a dependent, in an OGB-offered health plan, **not** by the number of years you have been employed by a participating agency.