Form LG03
Revised 10/20

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
2021 CANCELLATION FORM

FOR LGHIB USE ONLY
Date: _____
Initials: _____

SUBSCRIBER INFORMATION (Please print or type.)

Name (First, Middle Initial, Last)	Date of Birth
Social Security Number	Contract Number

CANCEL ALL INSURANCE COVERAGE FOR THE FOLLOWING REASONS:
Signature not required for the following cancel reasons:

☐ Termination _____ ☐ Voluntary ☐ Involuntary
Last Day in Pay Status

☐ Declination of Coverage. (You MUST complete and submit a "Declination of Coverage" form.)

☐ Military Leave Date _____ Attach military papers.

☐ Leave Without Pay - non-payment _____

☐ Death _____

☐ Retirement Date _____ Unit does not allow retiree coverage

☐ Retiree Non-Payment _____ COBRA **will not** be offered.

☐ For Medicare retirees, the Local Government Unit affirms it has provided the retiree with CMS' 21–day notice of disenrollment

☐ Other Date _____ Give explanation: _____

Signature is required to cancel coverage for the following reasons:

☐ Retiree Requested Cancellation _____

☐ Other - Date _____ Give explanation: _____

For units that provide retiree coverage, the following must be completed:

☐ Retirement Date _____

☐ Employee is eligible for and was offered LGHIP retiree health insurance coverage, but declined.

Note: By submitting this Cancellation Form, coverage with the LGHIP will be terminated.

AFFIRMATION AND RELEASE

I hereby affirm that I have completely read and fully understand the terms and conditions of this form. I attest that all the representations made by me on this form are true and correct. I understand that any misrepresentation may result in the forfeiture of insurance coverage and that I will be personally liable for all claims related to such misrepresentation. I further understand that there is mandatory utilization review and I do hereby give permission to release any information necessary to evaluate, administer, and process claims for benefits to any person, entity or representative acting on the LGHIB's behalf.

_____ _____
Employee Signature Date

TO BE COMPLETED BY EMPLOYER

Requested Effective Date of Cancellation*: _____
**LGHIP may revise this date without notifying the unit if the requested date is incorrect*

Local Government Unit Name: _____ **Unit Number:** _____

Signature of Benefit Administrator: _____ **Date:** _____

LOCAL GOVERNMENT HEALTH INSURANCE BOARD | PO BOX 304900 | MONTGOMERY, ALABAMA 36130-4900
(334) 263-8326 • 1-866-836-9137 • FAX: (334) 263-8526

For LGHIB Use Only
☐ Send COBRA _____
☐ Check Claims _____
☐ Credit _____