Form LG03
Revised 9/19

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
2020 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:

_____ Voluntary Termination _____
Last Day in Pay Status

_____ Involuntary Termination _____
Last Day in Pay Status

_____ Retirement Date _____ Unit does not allow retiree coverage

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

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

_____ Military Leave Date _____ Attach military papers.

_____ Death _____

_____ Leave Without Pay - non-payment _____

_____ Other Date _____ Give explanation: _____

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

Signature is required to cancel coverage for the following reasons:

_____ Retirement Date _____ Unit allows retiree coverage

_____ Retiree – Requested _____

_____ Other Date _____ Give explanation: _____

Note: By submitting this Cancellation Form, health insurance coverage 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

Effective Date of Cancellation: _____

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

Signature of Insurance Clerk: _____ **Date:** _____

LOCAL GOVERNMENT HEALTH INSURANCE BOARD
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☐ Send COBRA _____
☐ Check Claims _____
☐ Credit _____