Form LG08
Revised 8/23

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
CHANGE FORM
SOUTHLAND VOLUNTARY INSURANCE

PARTICIPANT INFORMATION (Please print or type.)

Name (First, Middle Initial, Last)	Social Security Number

Please indicate the Southland Plan to which you are requesting a change:

☐ Vision ☐ Dental ☐ Vision & Dental

Must have a qualifying event to drop dependent coverage outside Open Enrollment. A "qualifying event" is birth, marriage, adoption, death, divorce, or otherwise losing dependent status. Dependent documentation is required before dependents can be added or dropped due to a qualifying event. Notification must be submitted to the LGHIB within 60 days of the qualifying event.

DROP DEPENDENT COVERAGE
(Must select one)

☐ Change from Family to Single Coverage

☐ Cancel dependent(s) listed below from Family Coverage

ADDITIONS
(Must select one). Please read important information on the back.

☐ Change from Single to Family Coverage. Add dependent(s)

☐ Add dependent(s) listed below to Family Coverage

REASON FOR CANCEL (Must select one) **MONTH/DAY/YEAR**

☐ Open Enrollment 01/01/2024

☐ Death _____

☐ Divorce _____
Attach divorce decree

☐ Dependent no longer eligible _____

Explain: _____

☐ Other qualifying event: _____

Explain: _____

REASON FOR ADDITION (Must select one) **MONTH/DAY/YEAR**

☐ Open Enrollment 01/01/2024

☐ Marriage _____

☐ Birth/Adoption of Child _____

☐ Other: _____

Explain: _____

If adding dependent due to a qualifying event, effective date of coverage will be the date of the qualifying event. If there is no qualifying event, the effective date of coverage will be the first day of the month following receipt of this form by the LGHIB.

First Name Initial Last Name	Relationship to Participant (Male or Female Spouse, Son, Daughter, Stepson, Stepdaughter, Male or Female Custodial Dependent)	Date of Birth	Social Security Number

AFFIRMATION AND RELEASE

I understand and acknowledge that only eligible dependents may be added to my coverage. I understand it is my responsibility to notify the LGHIB immediately when the eligibility of a covered dependent changes. If it is determined that an act on my part (such as adding an ineligible person to coverage) or omission (such as failing to remove a person no longer eligible for coverage) results in or contributes to the payment of claims for persons ineligible for coverage, I will be personally responsible for all such overpayments and may be subject to disqualification from coverage under the plan.

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 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.

_____ _____
Participant Signature Date

TO BE COMPLETED BY EMPLOYER

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

If signed electronically, I acknowledge and certify the electronic signature process complies with the Alabama Uniform Electronic Transaction Act and the LGHIB rules outlined in the Administrative Guide.

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

GENERAL INFORMATION

Eligible Dependent

(Appropriate documentation must be attached.)

The term "dependent" includes the following individuals, subject to appropriate documentation (Social Security number, marriage certificate, birth certificate, court decree, etc.).

- The participant's spouse (excludes a divorced spouse)
- A child under age 26, only if the child is:
  - The participant's son or daughter
  - A child legally adopted by the participant or their spouse
  - The participant's stepchild
- A dependent, under age 19, for whom the participant, or his or her spouse, has legal and physical custody granted by a court of competent jurisdiction
- An incapacitated child* over age 25 will be considered for coverage provided the dependent child is:
  - unmarried,
  - permanently mentally or physically disabled or incapacitated,
  - so incapacitated as to be incapable of self-sustaining employment,
  - dependent upon the participant for 50% or more financial support,
  - otherwise eligible for coverage as a dependent child except for age,
  - had the condition prior to the child's 26th birthday, and
  - not eligible for any other group insurance benefits.

*The above requirements must be met to be eligible for coverage as an incapacitated child. The LGHIB will decide whether an application for incapacitated status will be accepted and final approval of incapacitation will be determined by medical review conducted by BCBS. The LGHIB reserves the right to periodically recertify incapacitation. Neither a reduction in work capacity nor inability to find employment is, of itself, evidence of eligibility. If a mentally or physically incapacitated child is employed, the extent of their earning capacity will be evaluated.

See the "Enrolling an Incapacitated Child" section for critical enrollment deadlines. If deadlines are not met, coverage may be denied.

Ineligible Dependents

An individual who does not meet the definition of an eligible dependent shall not be allowed to be covered as a dependent under the LGHIP. Examples include, but are not limited to:

- A participant's spouse or other dependents if they are independently eligible for coverage as an employee of a participating unit
- An ex-spouse, regardless of what the divorce decree may state
- Ex-stepchildren, regardless of what the divorce decree may state
- Children age 26 and older
- Foster children
- Incapacitated children age 26 and older who do not meet the Incapacitated Child eligibility requirements
- A child of a dependent child
- A participant's child, if the child has been adopted by someone other than their spouse and the participant has been relieved of their parental rights and responsibilities
- A daughter-in-law or son-in-law
- Grandchildren or other individuals related to the participant by blood or marriage for which the participant does not have legal custody
- Grandchildren or other children age 19 and older regardless of whether the participant has legal custody
- Grandparents
- Parents
- A fiancé or live-in girlfriend or boyfriend

Enrolling an Incapacitated Child

To apply, contact the LGHIB to obtain an Incapacitated Child Certification form. A completed Incapacitated Child Certification form and proof of incapacity must be provided to the LGHIB no more than 60 days after the dependent's 26th birthday*. If the form and proof of incapacity is not submitted within the required time, the child is not eligible for future enrollment except in the following two situations:

- When a new participant requests coverage for an incapacitated child within 60 days of employment; or
- When a participant's incapacitated child is covered under a spouse's employer group health insurance for at least 18 consecutive months and:
  - the spouse loses the other coverage because:
    - the employer ceases operations, or
    - of termination of employment or reduction of hours of employment, or
    - the employer stopped contributing to coverage.

In these two situations, the child must meet all the Incapacitated Child eligibility requirements and submit an Incapacitated Child Certification form and a New Dependent form to the LGHIB within 60 days of the incapacitated child's loss of other coverage. The LGHIB will decide whether an application for incapacitated status will be accepted and final approval of incapacitation will be determined by medical review conducted by BCBS.

*The 60-day time limit does not apply to enrollment in a Southland Voluntary Plan.