Form LG02-B
Revised 5/18

FOR LGHIB USE ONLY
Date: _____
Initials: _____

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
2018 DEPENDENT CHANGE FORM

SUBSCRIBER INFORMATION (Please print or type.)

Name (First, Middle Initial, Last)			Date of Birth
Social Security Number	Contract Number	Home Telephone Number ( )	Work Telephone Number ( ) Ext.

DROP DEPENDENT COVERAGE

__ Change from Family to Single Coverage
__ Cancel dependent(s) listed below from Family Coverage

ADDITIONS – PROVIDE DOCUMENTATION
**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 MONTH/DAY/YEAR

Death _____
Divorce
Attach divorce decree _____
Dependent no longer eligible _____
Explain: _____
Other: _____
Explain: _____

REASON FOR ADDITION MONTH/DAY/YEAR

__ Marriage _____
Birth of Child _____
Adoption of Child _____
Other _____
Explain: _____

First Name Initial Last Name	Documentation is required. See back of form. Relationship to Employee		Date of Birth	Social Security Number
	☐ Male Spouse	☐ Female Spouse		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Grandson ☐ Nephew	☐ Granddaughter ☐ Niece		
	☐ Grandson ☐ Nephew	☐ Granddaughter ☐ Niece		

For additional dependents, please list the information on a separate sheet and attach to this form.

AFFIRMATION AND RELEASE

I understand and acknowledge that only eligible dependents may be added to my coverage. An ex-spouse and ex-stepchildren are ineligible for coverage and cannot be maintained as dependents under my family coverage regardless of a judgment or divorce decree requiring me to provide health care for my ex-spouse or ex-stepchildren. I understand and acknowledge that an ex-spouse and ex-stepchildren must be removed from coverage effective the first day of the month following the date of the divorce decree and 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 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 Change: _____

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

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

Dependent documentation is required before dependents can be added to coverage.

GENERAL INFORMATION

Eligible Dependent
(**Appropriate documentation must be attached.)**

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

1. Your spouse (excludes divorced spouse).
2. A child under age 26, only if the child is:
   a. your son or daughter. (A court decree establishing paternity will be temporarily effective for 60 days, at which time an amended birth certificate listing the father's name will be due.)
   b. a child legally adopted by you or your spouse,
   c. your stepchild,
3. Your grandchild, niece or nephew
   a. under 19 years of age, and
   b. for whom the court has granted custody to you or your spouse
4. An incapacitated dependent over age 25 will be considered for coverage provided dependent:
   a. is unmarried,
   b. is permanently mentally or physically disabled or incapacitated,
   c. is so incapacitated as to be incapable of self-sustaining employment,
   d. is dependent upon you for 50% or more financial support,
   e is otherwise eligible for coverage as a dependent except for age,
   f. the condition must have occurred prior to the dependent's 26th birthday, and
   g. is not eligible for any other group health insurance benefits.

Neither a reduction in work capacity nor inability to find employment is, of itself, evidence of eligibility. If a mentally or physically disabled dependent is working, despite his disability, the extent of his earning capacity will be evaluated.

To apply, contact the LGHIB to obtain an Incapacitated Dependent Certification Form. Final approval of incapacitation will be determined by Medical Review. Proof of disability must be provided to the LGHIB within 60 days from the date the child would cease to be covered because of age.

NOTE: The LGHIB reserves the right to periodically re-certify incapacitation.

Exception: There are two situations under which it may be possible to add an incapacitated dependent who otherwise meets the eligibility requirements except for age:

1. When a new employee requests coverage for an incapacitated dependent within 60 days of employment; or
2. When an employee's incapacitated dependent is covered under a spouse's employer group health insurance for at least 18 consecutive months and:
   a. the employee's spouse loses the other coverage because:
      - spouse's employer ceases operations, or
      - spouse's loss of eligibility due to termination of employment or reduction of hours of employment, or
      - spouse's employer stopped contribution to coverage,
   b. a change form is submitted to the LGHIB within 30 days of the incapacitated dependent's loss of other coverage, and
   c. Medical Review approved incapacitation status.

The above requirements must be met as a minimum threshold in order to be considered for incapacitation status. The LGHIB shall make the final decision as to whether an application for incapacitated status will be accepted.

NOTE: The LGHIB reserves the right to periodically re-certify incapacitation.

Exclusion: You may not cover your spouse or other dependents if they are insured or if they are eligible to be insured as an active employee in the Local Government Health Insurance Program.

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