Form LG02-C
Revised 10/20

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
2021 DEPENDENT 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	Primary Telephone Number ( )	Work Telephone Number ( ) Ext.

DROP DEPENDENT COVERAGE (Must select one)

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

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

☐ Death _____

☐ Divorce _____
Attach divorce decree

☐ No longer has legal custody _____
Attach court documents

☐ No longer has legal custody _____
Attach court documents

MONTH/DAY/YEAR

☐ Dependent eligible to be enrolled as an active employee with the LGHIP _____

☐ Dependent no longer eligible _____

Explain: _____

☐ Open Enrollment (Effective 1/1/2021) _____

☐ Other _____

Explain: _____

First Name	Initial	Last Name	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		
			☐ Grandson ☐ Nephew	☐ Granddaughter ☐ Niece		
			☐ Grandson ☐ Nephew	☐ Granddaughter ☐ Niece		

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*: _____
**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, AL 36130-4900
(334) 263-8326 • 1-866-836-9137 • FAX: (334) 263-8526

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