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| FOR LGHIB USE ONLY |
| Date: _____ |
| Initials: _____ |

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM 2019 STATUS 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. |
| CHANGE: <input type="checkbox"/> MAILING ADDRESS To: _____ <div style="text-align: center; margin-left: 150px;">Street Address or Post Office Box</div> <hr/> <div style="display: flex; justify-content: space-between; margin-left: 100px;"> City State Zip </div> <input type="checkbox"/> SUBSCRIBER'S NAME From: _____ To: _____ <input type="checkbox"/> DEPENDENT'S NAME From: _____ To: _____ <input type="checkbox"/> SUBSCRIBER'S DATE OF BIRTH From: _____ To: _____ <input type="checkbox"/> DEPENDENT'S DATE OF BIRTH From: _____ To: _____ <input type="checkbox"/> TELEPHONE NUMBER To: Home () Work: () <input type="checkbox"/> E-MAIL ADDRESS To: _____ | | | |

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|--|--|
| CHANGE RATE: <input type="checkbox"/> Retired Subscriber (Not Medicare Participant) <input type="checkbox"/> Dependent not Medicare <input type="checkbox"/> Dependent Medicare | CHANGE RATE: <input type="checkbox"/> Retired Subscriber (Medicare Participant) <input type="checkbox"/> Dependent not Medicare <input type="checkbox"/> Dependent Medicare |
|--|--|

Note: If in your rate above you selected: **Retired Subscriber (Medicare Participant)** or **Dependent Medicare**, you must provide a copy of your Red, White, and Blue Medicare Card.

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: _____