Form LG11-B
Revised 9/17

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
General Information Changes

Name of Local Government Unit_____ Account # _____

Mailing Address for Billing _____
Street Address

_____
City State

_____
ZIP Code County

Health Insurance Administrator _____
(If different from contact person for billing)

Position/Title _____Telephone_____

Unit E-Mail Address _____

Contact Person for Billing _____

Position/Title _____Telephone _____

Unit E-Mail Address _____

Additional Contact Person_____

Delete Contact Person _____

Form Completed By _____Date _____

Signature _____

FOR LGHIB USE ONLY. DO NOT WRITE IN THIS SPACE.

LGHIP UNIT # _____ **DATE**_____

EFFECTIVE DATE_____ **DENTAL**_____

RETIREES (NON-MEDICARE)_____ **(MEDICARE)** _____

NEW HIRES _____

ELECTED OFFICIALS _____