Form LG02
Revised 6/21

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
2021 STATUS CHANGE FORM

SUBSCRIBER INFORMATION (Please print or type.)

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

Select the change that needs to be made from the options below:

☐ MAILING ADDRESS To: ____
Street Address or Post Office Box

____
City State Zip

☐ SUBSCRIBER'S / ☐ DEPENDENT'S NAME* From: ____________________ To: ____________________

Documentation Required

☐ SUBSCRIBER'S / ☐ DEPENDENT'S DATE OF BIRTH From: ____________________ To: ____________________

☐ TELEPHONE NUMBER: To: Primary (_________)____________________ Work: (_________)____________________

☐ E-MAIL ADDRESS To: ____

Retirement
Check applicable boxes

Retiree: ☐ Not Medicare ☐ Medicare

☐ Retired due to Social Security Disability (provide disability determination letter)

☐ Retired based upon years of service (must provide form LG22)

Dependent: ☐ Not Medicare ☐ Medicare

Physical address of Medicare members must be provided.

____
Physical Street Address

____
City State Zip

Note: If in the section above you selected: ☒ **Retiree: Medicare** or ☒ **Dependent: Medicare,** you must provide a copy of your Red, White and Blue Medicare Card and a physical address. Your name must match the name listed on your Medicare card.

Other Group Health Insurance Information
Do you have additional insurance coverage other than LGHIP coverage? ☐ Yes ☐ No
If yes, you must complete this section.

Other Coverage Contract Holder Full Name	Health Insurance Company	Other Coverage Policy Number
Other Coverage Group Number	Other Coverage Contract Holder's Date of Birth	Other Coverage Effective Date

If other coverage includes prescription drug coverage, please complete the below (information can be found on your other coverage insurance card)

Rx BIN Number	Rx ID

AFFIRMATION AND RELEASE

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

Requested 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:** ____________

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