Form LG03
Revised 6/21

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
2021 CANCELLATION FORM

SUBSCRIBER INFORMATION (Please print or type.)

Name (First, Middle Initial, Last)	Date of Birth

Social Security Number	Contract Number

CANCEL ALL INSURANCE COVERAGE FOR THE FOLLOWING REASONS:
Signature not required for the following cancel reasons:

☐ Termination _____ (Last Day in Pay Status) ☐ Voluntary ☐ Involuntary
☐ Terminated due to gross misconduct

☐ Reduction of hours to less than 30 hours per week

☐ Declination of Coverage. (You MUST complete and submit a "Declination of Coverage" form.)

☐ Military Leave Date _____ Attach military papers.

☐ Leave Without Pay - non-payment _____

☐ Death _____

☐ Retirement Date _____ Unit does not allow retiree coverage

☐ Date Retiree became Eligible for Medicare _____ Unit does not allow Medicare Coverage

☐ Retiree Non-Payment _____ COBRA **will not** be offered.

☐ For Medicare retirees, the Local Government Unit affirms it has provided the retiree with CMS' 21–day notice of disenrollment

☐ Other Date _____ Give explanation: _____

Signature is required to cancel coverage for the following reasons:

☐ Retiree Requested Cancellation _____

☐ Other - Date _____ Give explanation: _____

For units that provide retiree coverage, the following must be completed:

☐ Retirement Date _____

☐ Employee is eligible for and was offered LGHIP retiree health insurance coverage, but declined.

Note: By submitting this Cancellation Form, coverage with the LGHIP will be terminated.

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 Cancellation*: _____
**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:** _____