Form LG07
Revised 10/20

FOR LGHIB USE ONLY

Date: _____

Initials: _____

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
2021 ENROLLMENT FORM
SOUTHLAND VOLUNTARY INSURANCE

SUBSCRIBER INFORMATION (Please print or type.)

Name (First, Middle Initial, Last)		Gender
Social Security Number		Date of Birth
Mailing Address		
City	State	ZIP Code
Primary Telephone Number ( )	Work Telephone Number ( ) Ext:	
E-mail Address:		

CHECK PLAN ELECTED

☐ Vision

☐ Dental

☐ Vision and Dental

A minimum enrollment of 12 months required for employees/ dependents without qualifying status change.

Employment Status (Check One)

☐ Full-time Employee ☐ ACA Eligible (Must submit form LG23) ☐ Elected Official ☐ Retired (Not Medicare Participant) ☐ Retired (Medicare Participant)

NOTE: BY LISTING FAMILY MEMBERS BELOW YOU ARE APPLYING FOR AND REQUESTING FAMILY COVERAGE.

First Name Initial Last Name	Documentation is required. See back of form. 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		
	☐ 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

Requested Effective Date*: _____

**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:**_____

* A "qualifying event" is birth, marriage, adoption, death, divorce, or otherwise losing dependent status.
Dependent documentation is required before dependents can be added to coverage.

GENERAL INFORMATION

Eligible Dependent
(Appropriate documentation must be attached.)

The term "dependent" includes the following individuals, subject to appropriate documentation (Social Security number, marriage documentation, birth documentation, court decree, etc.):

1. The eligible participant's spouse (excludes a divorced spouse)

2. A child under age 26, only if the child is:
   a) The eligible participant's son or daughter
   b) A child legally adopted by the eligible participant or his or her spouse
   c) The eligible participant's stepchild

3. Grandchild, niece or nephew of the eligible participant or his or her spouse:
   a) under 19 years of age, and
   b) for whom the court has granted custody to the eligible participant or his or her spouse

4. An incapacitated dependent over age 25 will be considered for coverage provided dependent:
   a) is unmarried,
   b) is permanently mentally or physically disabled or incapacitated,
   c) is so incapacitated as to be incapable of self-sustaining employment,
   d) is dependent upon the eligible participant for 50% or more financial support,
   e) is otherwise eligible for coverage as a dependent except for age,
   f) had the condition prior to the dependent's 26th birthday, and
   g) is not eligible for any other group insurance benefits

Neither a reduction in work capacity nor inability to find employment is, of itself, evidence of eligibility. If a mentally or physically disabled dependent is employed, the extent of his or her earning capacity will be evaluated.

To apply, contact the LGHIB to obtain an Incapacitated Dependent Certification Form. Final approval of incapacitation will be determined by Medical Review. Proof of disability must be provided to the LGHIB within 60 days from the date the child would otherwise cease to be covered because of age.

These requirements must be met as a minimum threshold in order to be considered for incapacitation status. The LGHIB shall make the decision as to whether an application for incapacitated status will be accepted. **NOTE:** The LGHIB reserves the right to periodically recertify incapacitation.

LOCAL GOVERNMENT HEALTH INSURANCE BOARD
POST OFFICE BOX 304900
MONTGOMERY, ALABAMA 36130-4900
(334) 263-8326 • 1-866-836-9137 • FAX: (334) 263-8526

LGHIB Dependent Eligibility
Definitions and Required Documents

TYPE OF DEPENDENT	DEFINITION	REQUIRED DOCUMENT(S) FOR VERIFICATION
Spouse	A person to whom the participant is legally married	• Government issued marriage certificate or other government issued document evidencing the marriage • Court documents recognizing marriage • Naturalization papers indicating marital status
		Common Law Marriage Only for common-law marriage that began before January 1, 2017. Alabama law requires clear and convincing evidence of the following basic requirements: • Both parties must have the present legal capacity to marry; • The parties must have entered into a mutual agreement to enter into a permanent marriage; and • There must be public recognition of the marital relationship and public assumption of marital duties and cohabitation. A member requesting to add a common law spouse will receive a letter from the LGHIB detailing necessary documentation.
Natural (biological) child	A natural (biological) child under age 26	• Birth certificate; or • Certificate of Report of Birth (DS-1350); or • Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240); or • Certificate of Birth Abroad
Adopted child	A child under age 26 the participant has adopted or is in the process of legally adopting	• Court documents filed with the court petitioning to adopt; or • Court documents signed by a judge showing that the participant has adopted the child; or • International adoption papers from country of adoptions; or • Papers from the adoption agency showing intent to adopt; or • Birth certificate
Custodial niece, nephew and/or grandchild	A niece, nephew or grandchild under age 19 for whom the participant is the legal guardian	Court Order that establishes guardianship
Stepchild	The biological or adopted child under age 26 of the participant's spouse	• Verification of marriage between employee and spouse (as outlined above) and birth certificate of the child showing the relationship to the spouse; or • Any legal document that establishes relationship between the stepchild and the participant's spouse
National Medical Support Notice child	A child who is named as an alternate recipient with respect to the participant under a National Medical Support Notice (NMSN)	NMSN issued by a state agency
Incapacitated Dependent	An unmarried dependent over the age of 25 (who falls under one of the categories previously listed) and due to a mental or physical disability, is unable to earn a living. The dependent's disability must have begun before age 26. The dependent must rely on the subscriber for 50% or more financial support and must not be eligible for other group insurance.	Completed Incapacitated Dependent Certification form to be evaluated by Medical Review.