Form LG09
Revised 10/20

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
2021 CANCELLATION FORM
SOUTHLAND VOLUNTARY INSURANCE
OPEN ENROLLMENT

FOR LGHIB USE ONLY

Date: _____

Initials: _____

SUBSCRIBER INFORMATION (Please print or type.)

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

CANCEL INSURANCE COVERAGE:

(Enrollment minimum of 12 months required without qualifying status change.)

☐ **Vision**

☐ **Dental**

☐ **Vision & Dental**

☐ **Termination of Employment. You must complete a Cancellation Form.**

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

Effective Date of Cancellation: 01/01/2021

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.

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