Form LG15
Revised 10/20

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM

Participation Form

1. Name of Local Government Unit _____

   The above-named group certifies the following numbers and percentages of eligible and enrolled participants at the date of application:

2. Active: Enrolled _____ Declined _____

   Elected: Enrolled _____ Declined _____

   Retired: Enrolled _____

   Total Eligible Participants: Enrolled _____ Declined _____

3. Eligible participants enrolled for single coverage _____

4. Eligible participants enrolled for family coverage _____

5. % of employee premium to be paid by employer _____

   % of employee premium to be paid by employee _____

6. % of dependent premium to be paid by employer _____

   % of dependent premium to be paid by employee_____

7. Dental option is elected for all employees? ☐ YES ☐ NO

8. Provide Coverage for Non-Medicare Retirees? ☐ YES ☐ NO

9. Provide Coverage for Medicare Retirees? ☐ YES ☐ NO

10. Provide Coverage for Elected Officials? ☐ YES ☐ NO
    (For cities, towns and counties)

11. Probationary period policy for new employees that affects benefits? ☐ YES ☐ NO
    If "yes," attach a copy of the policy.

IMPORTANT: Attach to this application package an alphabetical listing, by department, of employee names and Social Security numbers included in this local government unit.

_____ _____
Signature of Benefit Administrator Date

_____
Printed Name

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