Form LG22-A
Revised 10/20

FOR LGHIB USE ONLY
Date: ____________
Initials: ____________

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
2021 RETIREE YEARS OF SERVICE VERIFICATION
(Full Time Employment Only)

SUBSCRIBER INFORMATION (Please print or type.)

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

Years of Service with a Local Governmental Entity Participating in the Local Government Health Insurance Plan (LGHIP)

Provide the following information listing your years of service with a local government unit participating in the LGHIP.
(If you have service with a governmental unit not participating in the LGHIP, please complete the table on the back of this form)

Date of Hire & Date of Termination	Employer	Employer Address	Employer Telephone Number	Employer Human Resources Contact
Date of Hire: ____________ **Date of Termination:** ____________ _____ Years _____ Months				
Date of Hire: ____________ **Date of Termination:** ____________ _____ Years _____ Months				
Date of Hire: ____________ **Date of Termination:** ____________ _____ Years _____ Months				
____________ **Months**	**Is employee converting accrued leave days to retirement service credit?** ☐ **Yes** ☐ **No** **If so, how much time will be converted? (Insert months in the left column)**			
______ **Total Years** ______ **Total Months**	***If additional space is needed, please include other previous employers on a separate sheet of paper.**			

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

______________________________ ______________________
Benefit Administrator Signature **Date**

Form LG22-B
Revised 8/20

Years of Service with a Non-Participating Governmental Entity (Full-Time Employment Only)

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

If you are less than 60 years of age and have less than 25 years of service with a local government unit participating in the LGHIP, service with a governmental entity that does not participate in the LGHIP may be included in your years of service, if approved by the LGHIB. Provide that information in the table below.

Date of Hire & Date of Termination	Employer	Employer Address	Employer Telephone Number	Employer Human Resources Contact
Date of Hire: ______________________ **Date of Termination:** ______________________ _____ Years _____ Months				
Date of Hire: ______________________ **Date of Termination:** ______________________ _____ Years _____ Months				
Date of Hire: ______________________ **Date of Termination:** ______________________ _____ Years _____ Months				
______ **Total Years** ______ **Total Months**	***If additional space is needed, please include other previous employers on a separate sheet of paper.**			

Proof of full-time employment must be attached to this 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

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