Form LG02-C
Revised 1/22

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
2022 DEPENDENT CANCELLATION FORM

PARTICIPANT INFORMATION (Please print or type.)

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

DROP DEPENDENT COVERAGE (Must select one)

☐ Change from Family to Single Coverage ☐ Cancel dependent(s) listed below from Family Coverage

REASON FOR CANCEL
Must select one reason for cancelling dependent coverage

MONTH/DAY/YEAR

☐ Death ________________

☐ Divorce
Attach divorce decree ________________

☐ Loss of custody
Attach court documents ________________

☐ Medicare/Medicaid entitlement ________________

MONTH/DAY/YEAR

☐ Open Enrollment Effective January 1, 2022

☐ Dependent employed by a unit in the LGHIP ________________

Name of Unit: ________________________________

☐ Other Qualifying Event* ________________

Explain ________________________________

*Must include proof of qualifying event to drop a dependent outside of Open Enrollment

First Name Initial Last Name	Relationship to Participant: (Spouse, Son, Daughter, Stepson, Stepdaughter, Grandson, Granddaughter, Niece or Nephew)	Date of Birth	Social Security Number

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 coverage and that I will be personally liable for all claims related to such misrepresentation. I further understand and acknowledge that only eligible dependents may be covered under the Local Government Health Insurance Plan and I will be personally responsible for all claims for ineligible dependents.

____________________________ ______________________
Participant Signature Date

TO BE COMPLETED BY EMPLOYER

Requested Effective Date of Change: ____________**Unit Name:** ________________________ **Unit Number:** ________
**LGHIP may revise this date without notifying the unit if the requested date is incorrect*

If signed electronically, I acknowledge and certify the electronic signature process complies with the Alabama Uniform Electronic Transaction Act and the LGHIB rules outlined in the Administrative Guide.

Signature of Benefit Administrator: ________________________________ **Date:** ________________

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