

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
2022 STATUS CHANGE FORM

PARTICIPANT INFORMATION (Please print or type.)

Name (First, Middle Initial, Last) _____	Social Security Number _____
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Select the change that needs to be made from the options below:

- MAILING ADDRESS _____
Street Address or Post Office Box
- _____
- City State Zip
- PARTICIPANT'S / DEPENDENT'S NAME* From: _____ To: _____
**Documentation Required*
- PARTICIPANT'S / DEPENDENT'S DATE OF BIRTH From: _____ To: _____
- TELEPHONE NUMBER: Primary (_____) _____ Work: (_____) _____
- E-MAIL ADDRESS _____

Other Group Health Insurance Information

Do you have additional insurance coverage other than LGHIP coverage? Yes No
If yes, you must complete Other Group Health Insurance Addendum

**Retirement
Check applicable boxes**

- Retiree:** Not Medicare Medicare
- Must select one**
- Retired due to Social Security Disability (provide disability determination letter)
- Retired based upon years of service (must provide form LG22)
- Dependent:** Not Medicare Medicare

Physical address of Medicare members must be provided.

Physical Street Address

City State Zip

Note: If you selected: **Retiree: Medicare** or **Dependent: Medicare**, you must provide a copy of your Red, White and Blue Medicare Card and a physical address. Your name must match the name listed on your Medicare card.

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 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 LGHIP's behalf.

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 LGHIP rules outlined in the Administrative Guide.

Signature of Benefit Administrator: _____ **Date:** _____

