Form LG03
Revised 8/18

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
2019 CANCELLATION FORM

FOR LGHIB USE ONLY

Date: _____

Initials: _____

SUBSCRIBER INFORMATION (Please print or type.)

Name (First, Middle Initial, Last)	Date of Birth

Social Security Number	Contract Number

CANCEL ALL INSURANCE COVERAGE FOR THE FOLLOWING REASONS:

☐ Voluntary Termination _____
Last Day in Pay Status

☐ Involuntary Termination _____
Last Day in Pay Status

☐ Retirement Date _____

☐ Retiree Non-Payment _____ COBRA **will not** be offered.

☐ Military Leave Date _____ Attach military papers.

☐ Death _____

☐ Leave Without Pay - non-payment _____

☐ Other Date _____ Give explanation: _____

☐ Declination of Coverage. (You MUST complete and submit a "Declination of Coverage" form.)

Note: By submitting this Cancellation Form, health insurance coverage will be terminated.

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: _____

Local Government Unit Name: _____ **Account Number:** _____

Signature of Insurance Clerk: _____ **Date:** _____

LOCAL GOVERNMENT HEALTH INSURANCE BOARD
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