Form LG03
Revised 1/22

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
2022 CANCELLATION FORM

PARTICIPANT INFORMATION (Please print or type.)

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

CANCEL ALL INSURANCE COVERAGE FOR THE FOLLOWING REASONS:
Participant's signature is not required for the following cancel reasons:

☐ Termination _____ (Last Day in Pay Status) ☐ Voluntary ☐ Involuntary
☐ Terminated due to gross misconduct

☐ Reduction of hours to less than 30 hours per week

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

☐ Military Leave Date _____ Attach military papers.

☐ Leave Without Pay - Non-Payment _____

☐ Death _____

☐ Retirement Date _____ Unit does not allow retiree coverage

☐ Date Retiree became eligible for Medicare _____ Unit does not allow Medicare Coverage

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

☐ For Medicare retirees, the Unit affirms it has provided the retiree with CMS 21–day notice of disenrollment

☐ Other _____ Date _____

Participant's signature is required to cancel coverage for the following reasons:

☐ Retiree Requested Cancellation _____

☐ Other _____ Date _____

For units that provide retiree coverage, the following must be completed:

☐ Retirement Date _____

☐ Employee is eligible for and was offered LGHIP retiree health insurance coverage but declined.

AFFIRMATION

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 correct and I understand by submitting this form my coverage will be cancelled.

_____ Participant Signature

_____ Date

TO BE COMPLETED BY EMPLOYER

Requested Effective Date of Cancellation*: _____ **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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