Form LG05
Revised 8/18

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
2019 EFFECTIVE DATE OF COVERAGE ELECTION FORM

FOR LGHIB USE ONLY

Date: _____

Initials: _____

As a participant in good standing in the Local Government Health Insurance Program, we elect to have coverage for all future eligible full-time employees to be effective on the date of employment for the plan year beginning January 1**,** 2019.

We understand that this election must be applied uniformly to all new eligible full-time employees.

We further understand that this election is conditional upon approval by the Local Government Health Insurance Board and shall remain in effect until such time as the Local Government Health Insurance Board may determine otherwise.

LOCAL GOVERNMENT UNIT:
EFFECTIVE PLAN YEAR: BEGINNING JANUARY 1, 2019
AUTHORIZED AGENT'S NAME AND TITLE: (please print)
SIGNATURE:
DATE OF ELECTION AGREEMENT:

LOCAL GOVERNMENT HEALTH INSURANCE BOARD
POST OFFICE BOX 304900
MONTGOMERY, ALABAMA 36130-4900
(334) 263-8326 • 1-866-836-9137 • FAX: (334) 517-9778