Form LG11-B
Revised 8/18

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
General Information Changes

Name of Local Government Unit________________________________ Account # ________

Mailing Address ____
PO Box or Street Address

____
City State

____
ZIP Code County

Health Insurance Administrator ____
(If different from contact person for billing)

Position/Title ________________________________Telephone ______________________

Unit E-Mail Address ____

Contact Person for Billing ____

Position/Title ________________________________Telephone ______________________

Unit E-Mail Address ____

Additional Contact Person ____

Delete Contact Person ____

Form Completed By ________________________________ Date ______________________

Signature ____

For LGHIB Use Only. Do Not Write In This Space.

LGHIP Unit # _________________________ **Date**______________________

Effective Date_________________________ **Dental**______________________

Retirees (Non-Medicare)_______________ **(Medicare)** ____________________

New Hires ____

Elected Officials ____

Local Government Health Insurance Board
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Montgomery, AL 36130-4900
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