

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM

Local Government Unit			Unit #
Mailing Address	City	State	ZIP Code
Physical Address	City	State	ZIP Code

Unit Contacts

Health Insurance Administrator		Title	
Phone Number		Email Address	
Primary Contact (If Different)		Title	
Phone Number		Email Address	
Additional Contact (If Different)		Title	
Phone Number		Email Address	
Additional Contact (If Different)		Title	
Phone Number		Email Address	
Wellness Contact (If Different)		Title	
Phone Number		Email Address	
Physical Address		City	State ZIP Code
Delete Contact			

Updates to Coverage

Submit during Open Enrollment for a January 1 effective date

Dental Coverage for all employees	<input type="checkbox"/> Add	<input type="checkbox"/> Drop
Coverage for Non-Medicare Retirees	<input type="checkbox"/> Add	<input type="checkbox"/> Drop
Coverage for Medicare Retirees	<input type="checkbox"/> Add	<input type="checkbox"/> Drop
Coverage for Elected Officials	<input type="checkbox"/> Add	<input type="checkbox"/> Drop
Effective Date of Coverage	<input type="checkbox"/> Date of Hire	<input type="checkbox"/> 1 st Day of 2 nd Month

_____ Name of Benefit Administrator	_____ Title
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	_____ Date