Form LG22
Revised 7/25

# LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
# RETIREE COVERAGE ENROLLMENT FORM

## A. Retiree Information

| Name (First, Middle Initial, Last): | | Social Security Number: | |
|---|---|---|---|
| Street Address (Must include if Medicare retiree): | City: | State: | ZIP Code: |
| Mailing Address (if different from Street Address): | City: | State: | ZIP Code: |
| Primary Phone Number:<br>(  ) | E-Mail Address: | | |

## B. Retirement

**(Check all applicable boxes)**

Requested Retirement Date _____

Does employee have at least 10 years of coverage in the LGHIP **OR** if the unit has been participating in the plan less than 10 years, has the employee been enrolled in the LGHIP continuously from the date the unit joined the LGHIP?

Yes ☐ No ☐ Employee is not eligible for coverage. Please submit a cancellation form.

**Retiree is:** ☐ Not Medicare ☐ Medicare Provide Medicare Number (if applicable) _____

☐ Retired based upon 25 years of service (employee is 59 or under, please complete attached Years of Service form)

☐ Retired due to Age (Employee is 60 or older)

☐ Retired due to Social Security Disability (provide disability determination letter)

**Will retiree maintain single or family coverage?** **Single** ☐ Do not complete section C **Family** ☐ Complete section C

## C. Dependent Information

**If adding more than two dependents, please complete an additional copy of this form. Documentation is required before dependent can be added to coverage. See back of form for dependent requirements.**

| Name of Dependent<br>First, Middle Initial, Last | Relationship to Retiree | Gender | Date of Birth | Social Security Number | Medicare Eligibility |
|---|---|---|---|---|---|
| | ☐ Spouse<br>Date Married: | ☐ M<br>☐ F | | | ☐ Not Medicare<br>☐ Medicare<br>Provide Medicare Number: |
| | ☐ Biological<br>☐ Adopted<br>☐ Step<br>☐ Custodial | ☐ M<br>☐ F | | | ☐ Not Medicare<br>☐ Medicare<br>Provide Medicare Number: |

## Other Group Health Insurance Information

**Do you have additional insurance coverage other than LGHIP coverage?** ☐ Yes ☐ No

If yes, you must complete the attached Other Group Health Insurance Addendum on page 3.

## 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 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 Local Gov's behalf.

I understand and acknowledge that only eligible dependents may be added to my coverage. I understand and acknowledge that it is my responsibility to notify Local Gov immediately when the eligibility of a covered dependent changes. If it is determined that an act on my part (such as adding an ineligible person to coverage) or omission (such as failing to remove a person no longer eligible for coverage) results in or contributes to the payment of claims for persons ineligible for coverage, I will be personally responsible for all such overpayments and may be subject to disqualification from coverage under the plan.

_____ _____

**Retiree Signature** **Date**

## TO BE COMPLETED BY EMPLOYER

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

If signed electronically, I acknowledge and certify the electronic signature process complies with the Alabama Uniform Electronic Transaction Act and Local Gov rules outlined in the Administrative Guide.

**Signature of Benefit Administrator:** _____ **Date:** _____

**Local Gov Health and Wellness**

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