

## LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM CANCELLATION FORM

### PARTICIPANT INFORMATION (Please print or type)

Name (First, Middle Initial, Last) _____	Social Security Number _____
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#### 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 \_\_\_\_\_

☐ Reduction of hours to less than 30 hours per week  
(Cancellation will be prospective based on date form is received by LGHIB)

☐ Declination of Coverage \_\_\_\_\_  

Must provide proof of other acceptable coverage. Cannot submit copy of insurance card as proof.

Name of Insurance Company \_\_\_\_\_

Name of Employer (if applicable) \_\_\_\_\_

☐ Military Leave Date \_\_\_\_\_ Attach military papers.

☐ Leave Without Pay - Non-Payment \_\_\_\_\_

☐ Death \_\_\_\_\_  
Date of 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 \_\_\_\_\_

Terminated due to gross misconduct

COBRA will not be offered if terminated due to gross misconduct

#### 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 Local Gov rules outlined in the Administrative Guide.

**Signature of Benefit Administrator:** \_\_\_\_\_ **Date:** \_\_\_\_\_