Form LG02 Revised 9/24

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM MEMBER INFORMATION CHANGES FORM

PARTICIPANT INFORMATION (Please print or type.)					
Name (First, Middle Initial, Last)	Social Secur	ity Number			
Select the change that needs to be made from the options below:					
MAILING ADDRESS Street Address or Post Office Box					
City	State	Zip			
☐ PARTICIPANT'S / ☐ DEPENDENT'S NAME* From:	To:				
*Documentation Required					
☐ PARTICIPANT'S / ☐ DEPENDENT'S DATE OF BIRTH From:	To:				
☐ TELEPHONE NUMBER: Primary ()	Work: ()				
☐ E-MAIL ADDRESS					
Other Group Health Insurance Information					
Do you have additional insurance co					
	Other Group Health Insurance A	Addendum			
I hereby affirm that I have completely read and fully understand the terms and are true and correct. I understand that any misrepresentation may result in the misrepresentation. I further understand that there is mandatory utilization reviadminister, and process claims for benefits to any person, entity or represent	l conditions of this form. I attest that a forfeiture of coverage and that I will b ew and I do hereby give permission to	e personally liable for all claims related to such release any information necessary to evaluate,			
Participant Signature		Date			
TO BE COMPLE	TED BY EMPLOYER				
Requested Effective Date of Change:Unit Name: _ *LGHIP may revise this date without notifying the unit if the requested date is income.		Unit Number:			
If signed electronically, I acknowledge and certify the electronic signature process outlined in the Administrative Guide.	complies with the Alabama Uniform Elect	ronic Transaction Act and the Local Gov's rules			
Signature of Benefit Administrator:		Date:			

LOCAL GOV HEALTH AND WELLNESS (334) 851-6802 • 1-866-836-9137 enrollments@lghip.org

Other Group Health Insurance Addendum Must be completed if you, your spouse and/or dependents have any other coverage.

LIST EACH INSURANCE COMPANY SEPARATELY (ATTACH ADDITIONAL SHEETS IF NECESSARY)							
Name of Contract Holder	Contract Holder Da	_		Group #	Insurance Contract #		
Name of Insurance Company			Types of coverage (Check all that apply)				
,			☐ Hospitalization				
			□ Doctor's Visits				
Name of Employer				☐ Prescription Drugs			
				□ Dental			
If other coverage includes prescription drug coverage, please complete the below (information can be found on your other coverage insurance card)							
Rx BIN Number		Rx ID					
Are you or any of your dependents covered		e policy?			vered individual below) □ No		
Name(s) (First, Middle Name, Last)	Date of Birth			Coverage Effective	ve Date(s)		
LIST EACH INSURANCE COMPANY SEPARATELY (ATTACH ADDITIONAL SHEETS IF NECESSARY)							
Name of Contract Holder			,	Group #	Insurance Contract #		
Name of Insurance Company			Types of coverage (Check all that apply)				
			☐ Hospitalization				
				☐ Doctor's Visits			
Name of Employer			☐ Prescription Drugs				
			☐ Dental				
					6		
If other coverage includes prescription drug coverage, please complete the below (information can be found on your other coverage insurance card)							
Rx BIN Number Rx ID		Rx ID	טו				
Are you or any of your dependents covered on this insurance policy? Yes (list each covered individual below) No							
Name(s) (First, Middle Name, Last)	Date of Birth			Coverage Effective	ve Date(s)		
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