Form LG22-A
Reviewed 7/25

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
RETIREE YEARS OF SERVICE VERIFICATION

PARTICIPANT INFORMATION (Please print or type.)

Name (First, Middle Initial, Last)	Social Security Number:

Years of Service with a Governmental Entity
Proof of full-time employment must be attached to this form

Provide the following information listing your full-time years of service with a governmental entity. Please indicate whether the entity participated in the LGHIP at the time of your service. If you are less than 60 years of age and have less than 25 years of service with a local government unit participating in the LGHIP, service with a governmental entity that does not participate in the LGHIP may be included in your years of service, if approved by Local Gov Health and Wellness. Non-participating governmental entities would include employment with a local government, the State of Alabama, and active-duty military service. Provide all applicable information in the table below.

Date of Hire: _____/_____/_____	Employer:	Employer Telephone:
Date of Termination: _____/_____/_____ ____ Years _____ Months	Employer Address:	Employer HR Contact:
Date of Hire: _____/_____/_____	Employer:	Employer Telephone:
Date of Termination: _____/_____/_____ ____ Years _____ Months	Employer Address:	Employer HR Contact:
Date of Hire: _____/_____/_____	Employer:	Employer Telephone:
Date of Termination: _____/_____/_____ ____ Years _____ Months	Employer Address:	Employer HR Contact:
Date of Hire: _____/_____/_____	Employer:	Employer Telephone:
Date of Termination: _____/_____/_____ ____ Years _____ Months	Employer Address:	Employer HR Contact:

Is employee converting accrued leave days to 25 years of service requirement? ☐ **Yes (If yes, insert number of months below)**

_____ Months (12 months of maximum leave) ☐ **No**

_____ Total Years _____ Total Months

***If additional space is needed, please include other previous employers on a separate document.**

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.

_____ Participant Signature

_____ Date

TO BE COMPLETED BY EMPLOYER

Unit Name: _____ **Unit No.:** _____

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

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