LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM Unit Changes Form

Local Government Unit					Unit #		
ciling Address		<u>.</u> .	Ctot	-	710 0-40		
Mailing Address	Ci	ty	Stat	е	ZIP Code		
Physical Address	Ci	ty	Stat	е	ZIP Code		
Unit Contacts							
Health Insurance Administrator		Title					
Phone Number		Email Address					
Check this box if the Administrator requires a separate login for the unit's my.lghip account. If selected, the Administrator will receive an email with login details from the Local Gov team.							
Primary Contact (If Different)	ry Contact (If Different)			Title			
Phone Number		Email Address					
Check this box if the Primary Contact requires a separate login for the unit's my.lghip account. If selected, the Primary Contact will receive an email with login details from the Local Gov team.							
Additional Contact (If Different)		Title					
Phone Number		Email Address	mail Address				
Check this box if the Additional Contact requires a separate login for the unit's my.lghip account. If selected, the Additional Contact will receive an email with login details from the Local Gov team.							
Additional Contact (If Different) Title							
,							
Phone Number		Email Address					
Check this box if the Additional Contact requires a separate login for the unit's my.lghip account. If selected, the Additional Contact will receive an email with login details from the Local Gov team.							
Wellness Contact (If Different)		Title					
Phone Number		Email Address					
Physical Address		City		State	ZIP Code		
Check this box if the Wellness Contact requires a separate login for the unit's my.lghip account. If selected, the Wellness Contact will receive an email with login details from the Local Gov team.							
Delete Centest							
Delete Contact							
Updates to Coverage							
Submit during Open Enrollment for a January 1 effective date							
Dental Coverage for all employees		Add	☐ Drop				
Coverage for Non-Medicare Retirees		Add	☐ Drop				
Coverage for Medicare Retirees							
Coverage for Elected Officials		☐ Add ☐ Drop					
Effective Date of Coverage							
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				