

**LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM  
CHANGE FORM  
SOUTHLAND VOLUNTARY INSURANCE**

**PARTICIPANT INFORMATION (Please print or type.)**

Name (First, Middle Initial, Last)	Social Security Number
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Please indicate the Southland Plan to which you are requesting a change:  
 Vision                       Dental                       Vision & Dental  
 (Enrollment minimum of 12 months required without a qualifying event)

**Must have a qualifying event to drop dependent coverage outside Open Enrollment. A "qualifying event" is birth, marriage, adoption, death, divorce, or otherwise losing dependent status. Dependent documentation is required before dependents can be added or dropped due to a qualifying event. Notification must be submitted to the LGHIB within 60 days of the qualifying event.**

<b>DROP DEPENDENT COVERAGE</b> (Must select one)  <input type="checkbox"/> Change from Family to Single Coverage  <input type="checkbox"/> Cancel dependent(s) listed below from Family Coverage	<b>ADDITIONS</b> (Must select one). Please read important information on the back.  <input type="checkbox"/> Change from Single to Family Coverage. Add dependent(s)  <input type="checkbox"/> Add dependent(s) listed below to Family Coverage
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<b>REASON FOR CANCEL (Must select one)</b> <b>MONTH/DAY/YEAR</b>  <input type="checkbox"/> Open Enrollment                      01/01/2023 <input type="checkbox"/> Death    _____ <input type="checkbox"/> Divorce Attach divorce decree                      _____ <input type="checkbox"/> Dependent no longer eligible                      _____  Explain: _____  <input type="checkbox"/> Other qualifying event: _____  Explain: _____	<b>REASON FOR ADDITION (Must select one)</b> <b>MONTH/DAY/YEAR</b>  <input type="checkbox"/> Open Enrollment                      01/01/2023 <input type="checkbox"/> Marriage    _____ <input type="checkbox"/> Birth/Adoption of Child                      _____ <input type="checkbox"/> Other:    _____  Explain: _____  If adding dependent due to a qualifying event, effective date of coverage will be the date of the qualifying event. If there is no qualifying event, the effective date of coverage will be the first day of the month following receipt of this form by the LGHIB.
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First Name	Initial	Last Name	Relationship to Participant (Male or Female Spouse, Son, Daughter, Stepson, Stepdaughter, Male or Female Custodial Dependent)	Date of Birth	Social Security Number

**AFFIRMATION AND RELEASE**

I understand and acknowledge that only eligible dependents may be added to my coverage. I understand it is my responsibility to notify the LGHIB 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.

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 the LGHIB's behalf.

\_\_\_\_\_    \_\_\_\_\_  
 Participant Signature    Date

**TO BE COMPLETED BY EMPLOYER**

**Requested Effective Date of Change\*:** \_\_\_\_\_ **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 LGHIB rules outlined in the Administrative Guide.

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

# GENERAL INFORMATION

## Eligible Dependent

(Appropriate documentation must be attached.)

The term "dependent" includes the following individuals, subject to appropriate documentation (Social Security number, marriage certificate, birth certificate, court decree, etc.).

- The participant's spouse (excludes a divorced spouse)
- A child under age 26, only if the child is:
  - The participant's son or daughter
  - A child legally adopted by the participant or their spouse
  - The participant's stepchild
- A dependent, under age 19, for whom the participant, or his or her spouse, has been granted legal and physical custody by a court of competent jurisdiction
- An incapacitated child\* over age 25 will be considered for coverage provided the dependent child is:
  - unmarried,
  - permanently mentally or physically disabled or incapacitated,
  - incapable of self-sustaining employment,
  - dependent upon the participant for 50% or more financial support,
  - otherwise eligible for coverage as a dependent child except for age,
  - had the condition prior to the child's 26th birthday, and
  - not eligible for any other group insurance benefits.

\*The above requirements must be met to be eligible for coverage as an incapacitated child. The LGHIB will decide whether an application for incapacitated status will be accepted and final approval of incapacitation will be determined by medical review conducted by Blue Cross and Blue Shield of Alabama. The LGHIB reserves the right to periodically recertify incapacitation. Neither a reduction in work capacity nor inability to find employment is, of itself, evidence of eligibility. If a mentally or physically incapacitated child is employed, the extent of their earning capacity will be evaluated.

See the "Enrolling an Incapacitated Child" section for critical enrollment deadlines. If deadlines are not met, coverage may be denied.

## Ineligible Dependents

An individual who does not meet the definition of an eligible dependent under the LGHIP rules. Examples include, but are not limited to:

- A participant's spouse or other dependents if they are independently eligible for coverage as an employee of a participating unit
- An ex-spouse, or ex-stepchildren, regardless of what the divorce decree may state
- Children aged 26 and older
- Foster children
- Incapacitated children aged 26 and older who do not meet the Incapacitated Child eligibility requirements
- A child of a dependent child
- A participant's child, if the child has been adopted by someone other than their spouse and the participant has been relieved of their parental rights and responsibilities
- A daughter-in-law or son-in-law
- Grandchildren or other individuals related to the participant by blood or marriage for which the participant does not have legal and physical custody
- Grandchildren, nieces, or nephews aged 19 and older regardless of whether the participant has legal and physical custody
- Grandparents
- Parents
- A fiancé or live-in girlfriend or boyfriend

## Enrolling an Incapacitated Child

To apply, contact the LGHIB to obtain an Incapacitated Child Certification form. A completed Incapacitated Child Certification form and proof of incapacity must be provided to the LGHIB no more than 60 days after the dependent's 26th birthday\*. If the form and proof of incapacity is not submitted within the required time, the child is not eligible for future enrollment except in the following two situations:

- When a new participant requests coverage for an incapacitated child within 60 days of employment; or
- When a participant's incapacitated child is covered under a spouse's employer group health insurance for at least 18 consecutive months and:
  - the spouse loses the other coverage because:
    - the employer ceases operations, or
    - of termination of employment or reduction of hours of employment, or
    - the employer stopped contributing to coverage,
- a New Dependent form is submitted to the LGHIB within 60 days of the incapacitated child's loss of other coverage, and
- Medical review approved incapacitation status.

In these two situations, the child must meet all the Incapacitated Child eligibility requirements.

\*The 60-day time limit does not apply to enrollment in a Southland Voluntary Plan.