Form LG15
Revised 8/22

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
Participation Form

Local Government Unit			Federal ID Number	
Mailing Address	City	State	ZIP Code	County
Physical Address	City	State	ZIP Code	County

Unit Contacts	
Health Insurance Administrator	
Name	Title
Phone Number	Email Address
Primary Contact (If different)	
Name	Title
Phone Number	Email Address
Additional Contact (If different)	
Name	Title
Phone Number	Email Address
Wellness Contact (If Different)	
Name	Title
Phone Number	Email Address

Physical Address	City	State	ZIP Code	County

Coverage Selections	
New units must select coverage allowances and effective date of coverage for all new eligible employees. Units may change these selections during Open Enrollment (Nov. 1- Nov. 30).	
BCBS Dental Coverage	☐ Yes ☐ No
Coverage for Non-Medicare Retirees	☐ Yes ☐ No
Coverage for Medicare Retirees	☐ Yes ☐ No
Coverage for Elected Officials (For Cities, Towns or Counties)	☐ Yes ☐ No **All municipalities and counties must complete form LG28 or LG29**
Effective Date of Coverage	☐ Date of Hire ☐ 1st Day of 2nd Month

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Enrollments/Declinations		
Please include the number of eligible employees who will enroll in, or decline, LGHIP coverage.		
Active Employees	Enroll:	Decline:
Elected Officials	Enroll:	Decline:
Retired	Enroll:	
Total Eligible Participants	Enroll:	Decline:
Total Number of Individuals Currently on COBRA:		

Contribution Amount		
Please provide the percentage the unit will contribute to the single and family premium		
Single Coverage Participants	Number of Participants:	
	% Paid by Unit:	% Paid by Employee:
Family Coverage Participants	Number of Participants:	
	% Paid by Unit:	% Paid by Employee:

Attach to this application package an alphabetical listing, by department, of all eligible employees' names and last four of their Social Security numbers. Please also include a list of all individuals currently enrolled in COBRA.

_____ _____
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 of Benefit Administrator Date

For LGHIB Use Only	
Date Coverage Will Begin	Unit #: