Form LG22
Revised 9/24

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
RETIREE COVERAGE ENROLLMENT FORM

A. Retiree Information

Name (First, Middle Initial, Last):			Social Security Number:
Street Address (Must include if Medicare retiree):	City:	State:	ZIP Code:
Mailing Address (if different from Street Address):	City:	State:	ZIP Code:
Primary Phone Number: ( )	E-Mail Address:		

B. Retirement

(Check all applicable boxes)

Requested Retirement Date ___________________________________

Does employee have at least 10 years of coverage in the LGHIP **OR** if the unit has been participating in the plan less than 10 years, has the employee been enrolled in the LGHIP continuously from the date the unit joined the LGHIP?

Yes ☐ No ☐ Employee is not eligible for coverage. Please submit a cancellation form.

Retire is: ☐ Not Medicare ☐ Medicare Provide Medicare Number (if applicable) ________________________________

☐ Retired based upon 25 years of service (employee is 59 or under, please complete attached Years of Service form)

☐ Retired due to Age (Employee is 60 or older)

☐ Retired due to Social Security Disability (provide disability determination letter)

Will retiree maintain single or family coverage? **Single** ☐ Do not complete section C **Family** ☐ Complete section C

C. Dependent Information

If adding more than two dependents, please complete an additional copy of this form. Documentation is required before dependent can be added to coverage. See back of form for dependent requirements.

Dependent's Name (First, Middle, Last)	Relationship to Employee (Male or Female Spouse, Son, Daughter, Stepson, Stepdaughter, Male or Female Custodial Dependent)	Date of Birth	Social Security Number	Medicare Eligibility
				☐ Not Medicare ☐ Medicare Provide Medicare Number:
				☐ Not Medicare ☐ Medicare Provide Medicare Number:

Other Group Health Insurance Information

Do you have additional insurance coverage other than LGHIP coverage? ☐ Yes ☐ No

If yes, you must complete the attached Other Group Health Insurance Addendum on page 3.

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. 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.

I understand and acknowledge that only eligible dependents may be added to my coverage. I understand and acknowledge that 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.

______________________________ ______________________

Retiree Signature **Date**

TO BE COMPLETED BY EMPLOYER

Local Government Unit Name: ____________________________________ **Unit Number:** __________

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:** ________________________

Local Government Health Insurance Board

(334) 851-6802 • 1-866-836-9137 • Enrollments@lghip.org

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 legal and physical custody granted by a court of competent jurisdiction
- An incapacitated child* over age 26 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 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 age 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.

Form LG22
Reviewed 7/24

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 the LGHIB. 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 LGHIB rules outlined in the Administrative Guide.

Signature of Benefit Administrator: ________________________________ **Date:** ____________________