

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM Unit Change Form

Local Government Unit			Unit #
Mailing Address	City	State	ZIP Code
Physical Address	City	State	ZIP Code

Unit Contacts

Health Insurance Administrator	Title		
Phone Number	Email Address		
Primary Contact (If Different)	Title		
Phone Number	Email Address		
Additional Contact (If Different)	Title		
Phone Number	Email Address		
Additional Contact (If Different)	Title		
Phone Number	Email Address		
Wellness Contact (If Different)	Title		
Phone Number	Email Address		
Physical Address	City	State	ZIP Code
Delete Contact			

Updates to Coverage

Submit during Open Enrollment for a January 1 effective date

Dental Coverage for all employees	<input type="checkbox"/> Add	<input type="checkbox"/> Drop
Coverage for Non-Medicare Retirees	<input type="checkbox"/> Add	<input type="checkbox"/> Drop
Coverage for Medicare Retirees	<input type="checkbox"/> Add	<input type="checkbox"/> Drop
Coverage for Elected Officials	<input type="checkbox"/> Add	<input type="checkbox"/> Drop
Effective Date of Coverage	<input type="checkbox"/> Date of Hire	<input type="checkbox"/> 1 st Day of 2 nd Month

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