Form LG09
Revised 1/23

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
CANCELLATION FORM
SOUTHLAND VOLUNTARY INSURANCE
OPEN ENROLLMENT

PARTICIPANT INFORMATION (Please print or type)

Name (First, Middle Initial, Last)	Social Security Number

To cancel Southland Voluntary Insurance, participant must have been enrolled a minimum of 12-months, If employee was terminated, a Cancellation form (LG03) must be completed.

☐ Vision	☐ Dental	☐ Vision and Dental

AFFIRMATION

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 correct and I understand by submitting this form my Southland Voluntary Insurance coverage will be cancelled.

_____ _____
Participant Signature Date

TO BE COMPLETED BY EMPLOYER

Effective Date of Cancellation: 01/01/2023 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:** _____

LOCAL GOVERNMENT HEALTH INSURANCE BOARD
(334) 851-6802 • 1-866-836-9137
Enrollments@lghip.org