Form LG05
Revised 7/25

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
NEW DEPENDENT FORM

PARTICIPANT INFORMATION (Please print or type.)

Name (First, Middle Initial, Last)		Date of Birth
Social Security Number	**Primary Telephone Number**	**Work Telephone Number**
	( )	( ) Ext.

ADDITIONS – PROVIDE DOCUMENTATION (Must select one) **Please read important information on the back.

☐ Change from Single to Family Coverage. Add dependent(s)** ☐ Add dependent(s) listed below to Family Coverage **

Reason for Addition (Must Select One)
Documentation is required before dependents can be added to coverage. See back of form for details.

	MONTH/DAY/YEAR		MONTH/DAY/YEAR
☐ Marriage	_____	☐ Open Enrollment	January 1
☐ Birth of Child	_____	☐ Special Enrollment due to loss of coverage	_____
☐ Adoption of Child	_____		
☐ Legal and Physical Custody	_____	☐ Other	_____

Explain: _____

Name of Dependent First, Middle Initial, Last	Relationship to Participant	Gender	Date of Birth	Social Security Number
	☐ Spouse Date Married:	☐ M ☐ F		
	☐ Biological ☐ Adopted ☐ Step ☐ Custodial	☐ M ☐ F		
	☐ Biological ☐ Adopted ☐ Step ☐ Custodial	☐ M ☐ F		
	☐ Biological ☐ Adopted ☐ Step ☐ Custodial	☐ M ☐ F		
	☐ Biological ☐ Adopted ☐ Step ☐ Custodial	☐ M ☐ F		
	☐ Biological ☐ Adopted ☐ Step ☐ Custodial	☐ M ☐ F		
	☐ Biological ☐ Adopted ☐ Step ☐ Custodial	☐ M ☐ F		

For additional dependents, please list the information on a separate sheet and attach to this form.

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 Local Gov 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 Local Gov's behalf.

_____ _____
Employee Signature Date

TO BE COMPLETED BY EMPLOYER

Requested Effective Date of Addition*: _____ **Unit Name:** _____ **Unit No.:** _____
**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 Local Gov rules outlined in the Administrative Guide.

Signature of Benefit Administrator: _____ **Date:** _____

Local Gov Health and Wellness
(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 25 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.

Other Group Health Insurance Addendum

Must be completed if you, your spouse and/or dependents have any other coverage.

LIST EACH INSURANCE COMPANY SEPARATELY (ATTACH ADDITIONAL SHEETS IF NECESSARY)			
Name of Contract Holder	Contract Holder Date of Birth	Group #	Insurance Contract #
Name of Insurance Company		Types of coverage (Check all that apply) ☐ Hospitalization ☐ Doctor's Visits ☐ Prescription Drugs ☐ Dental	
Name of Employer			
If other coverage includes prescription drug coverage, please complete the below (information can be found on your other coverage insurance card)			
Rx BIN Number	Rx ID		

Are you or any of your dependents covered on this insurance policy? ☐ Yes (list each covered individual below) ☐ No

Name(s) (First, Middle Name, Last)	Date of Birth	Coverage Effective Date(s)

LIST EACH INSURANCE COMPANY SEPARATELY (ATTACH ADDITIONAL SHEETS IF NECESSARY)			
Name of Contract Holder	Contract Holder Date of Birth	Group #	Insurance Contract #
Name of Insurance Company		Types of coverage (Check all that apply) ☐ Hospitalization ☐ Doctor's Visits ☐ Prescription Drugs ☐ Dental	
Name of Employer			
If other coverage includes prescription drug coverage, please complete the below (information can be found on your other coverage insurance card)			
Rx BIN Number	Rx ID		

Are you or any of your dependents covered on this insurance policy? ☐ Yes (list each covered individual below) ☐ No

Name(s) (First, Middle Name, Last)	Date of Birth	Coverage Effective Date(s)