

PARTICIPATION FORM: FORM LG15

Local Government Unit: _____ Federal ID Number: _____

Mailing Address: _____

City: _____ County: _____ State: _____ Zip: _____

Physical Address: _____

City: _____ County: _____ State: _____ Zip: _____

UNIT CONTACTS

Health Insurance Administrator

Name: _____ Title: _____

Phone: _____ Email: _____

Check this box if the Administrator requires a separate login for the unit's my.lghip account. If selected, the Administrator will receive an email with login details from the Local Gov team.

Primary or Billing Contact (if different)

Name: _____ Title: _____

Phone: _____ Email: _____

Check this box if the Administrator requires a separate login for the unit's my.lghip account. If selected, the Administrator will receive an email with login details from the Local Gov team.

Check this box if this contact is the same as the Health Insurance Administrator.

Additional Contact (if different)

Name: _____ Title: _____

Phone: _____ Email: _____

Check this box if the Administrator requires a separate login for the unit's my.lghip account. If selected, the Administrator will receive an email with login details from the Local Gov team.

Check this box if this contact is the same as the Health Insurance Administrator.

Wellness Contact (if different)

Name: _____ Title: _____

Phone: _____ Email: _____

Physical Address: _____ City: _____ State: _____ Zip: _____

Check this box if the Administrator requires a separate login for the unit's my.lghip account. If selected, the Administrator will receive an email with login details from the Local Gov team.

Check this box if this contact is the same as the Health Insurance Administrator.

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	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Coverage for Non-Medicare Retirees	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Coverage for Medicare Retirees	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Coverage for Elected Officials	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(for Cities, Towns, or Counties)		
Effective Date of Coverage	<input type="checkbox"/> Date of Hire	<input type="checkbox"/> 1st Day of 2 nd Month

ENROLLMENTS/DECLINATIONS

	Enroll:	Decline:	Not Applicable:
Active Employees			
Elected Officials			
Retired			
Total Number of Individuals Currently on COBRA			
Total Eligible Participants			

CONTRIBUTION AMOUNT

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 #: _____