Form LG03
Reviewed 7/25

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
CANCELLATION FORM

PARTICIPANT INFORMATION (Please print or type)

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

CANCEL ALL INSURANCE COVERAGE FOR THE FOLLOWING REASONS:
Participant's signature is not required for the following cancel reasons:

☐ Termination _____ ☐ Voluntary ☐ Involuntary
Last Day in Pay Status
☐ Terminated due to gross misconduct

COBRA will not be offered if terminated due to gross misconduct

☐ Reduction of hours to less than 30 hours per week
(Cancellation will be prospective based on date form is received by LGHIB)

☐ Declination of Coverage _____
Name of Insurance Company

Must provide proof of other acceptable coverage. Cannot submit copy of insurance card as proof.

_____
Name of Employer (if applicable)

☐ Military Leave Date _____ Attach military papers.

☐ Leave Without Pay - Non-Payment _____

☐ Death _____
Date of Death

☐ Retirement Date _____ Unit does not allow retiree coverage

☐ Date Retiree became eligible for Medicare _____ Unit does not allow Medicare Coverage

☐ Retiree Non-Payment _____ COBRA **will not** be offered.

☐ For Medicare retirees, the Unit affirms it has provided the retiree with CMS 21–day notice of disenrollment

☐ Other _____ Date _____

Participant's signature is required to cancel coverage for the following reasons:

☐ Retiree Requested Cancellation _____

☐ Other _____ Date _____

For units that provide retiree coverage, the following must be completed:

☐ Retirement Date _____

☐ Employee is eligible for and was offered LGHIP retiree health insurance coverage but declined

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 coverage will be cancelled.

_____ _____
Participant Signature Date

TO BE COMPLETED BY EMPLOYER

Requested Effective Date of Cancellation*: _____ **Unit Name:** _____ **Unit Number:** _____
**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:** _____