

## LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM CANCELLATION FORM

**PARTICIPANT INFORMATION** (Please print or type)

Name (First, Middle Initial, Last)	Social Security Number
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**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
- Reduction of hours to less than 30 hours per week
- Declination of Coverage \_\_\_\_\_  

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

Name of Insurance Company \_\_\_\_\_  
 Name of Employer (if applicable) \_\_\_\_\_

COBRA will not be offered if terminated due to gross misconduct
- 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:** \_\_\_\_\_