Form LG22
Revised 7/25

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
RETIREE COVERAGE ENROLLMENT FORM

A. Retiree Information

Name (First, Middle Initial, Last):		Social Security Number:	
Street Address (Must include if Medicare retiree):	City:	State:	ZIP Code:
Mailing Address (if different from Street Address):	City:	State:	ZIP Code:
Primary Phone Number: ( )	E-Mail Address:		

B. Retirement

(Check all applicable boxes)

Requested Retirement Date _____

Does employee have at least 10 years of coverage in the LGHIP **OR** if the unit has been participating in the plan less than 10 years, has the employee been enrolled in the LGHIP continuously from the date the unit joined the LGHIP?

Yes ☐ No ☐ Employee is not eligible for coverage. Please submit a cancellation form.

Retiree is: ☐ Not Medicare ☐ Medicare Provide Medicare Number (if applicable) _____

☐ Retired based upon 25 years of service (employee is 59 or under, please complete attached Years of Service form)

☐ Retired due to Age (Employee is 60 or older)

☐ Retired due to Social Security Disability (provide disability determination letter)

Will retiree maintain single or family coverage? **Single** ☐ Do not complete section C **Family** ☐ Complete section C

C. Dependent Information

If adding more than two dependents, please complete an additional copy of this form. Documentation is required before dependent can be added to coverage. See back of form for dependent requirements.

Name of Dependent First, Middle Initial, Last	Relationship to Retiree	Gender	Date of Birth	Social Security Number	Medicare Eligibility
	☐ Spouse Date Married:	☐ M ☐ F			☐ Not Medicare ☐ Medicare Provide Medicare Number:
	☐ Biological ☐ Adopted ☐ Step ☐ Custodial	☐ M ☐ F			☐ Not Medicare ☐ Medicare Provide Medicare Number:

Other Group Health Insurance Information

Do you have additional insurance coverage other than LGHIP coverage? ☐ Yes ☐ No

If yes, you must complete the attached Other Group Health Insurance Addendum on page 3.

AFFIRMATION AND RELEASE

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.

I understand and acknowledge that only eligible dependents may be added to my coverage. I understand and acknowledge that 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.

_____ _____

Retiree Signature **Date**

TO BE COMPLETED BY EMPLOYER

Local Government Unit Name: _____ **Unit Number:** _____

If signed electronically, I acknowledge and certify the electronic signature process complies with the Alabama Uniform Electronic Transaction Act and 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