Form LG09
Revised 9/24

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
CANCELLATION FORM
SOUTHLAND VOLUNTARY INSURANCE
OPEN ENROLLMENT

PARTICIPANT INFORMATION (Please print or type)

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

If employee was terminated, a Cancellation form (LG03) must be completed.

☐ Vision	☐ Dental	☐ Cancer

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 Southland Voluntary Insurance coverage will be cancelled.

_____ _____
Participant Signature Date

TO BE COMPLETED BY EMPLOYER

Effective Date of Cancellation: 01/01/2025 Unit Name: _____ Unit No.: _____

If signed electronically, I acknowledge and certify the electronic signature process complies with the Alabama Uniform Electronic Transaction Act and the Local Gov Health and Wellness rules outlined in the Administrative Guide.

Signature of Benefit Administrator: _____ Date: _____

LOCAL GOV HEALTH AND WELLNESS
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