Form LG04
Revised 9/24

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
NEW EMPLOYEE DECLINATION OF COVERAGE FORM

EMPLOYEE INFORMATION (Please print or type.)

Name (First, Middle Initial, Last)			Gender	Date of Birth
Social Security Number	Contract Number	Primary Phone Number ( )	Work Phone Number ( )	
Mailing Address		City	State	Zip Code

Employee Status: ☐ Full-time Employee ☐ ACA Eligible - Must submit form LG23) ☐ Elected Official

I, _____, wish to decline coverage in the Local Government Health
(name of local government employee)
Insurance Program. I affirm that I currently have other acceptable health insurance coverage* through _____
(name of employer/company)

My other insurance carrier is:

NAME OF INSURANCE COMPANY:		
ADDRESS:		
CITY:	STATE:	ZIP CODE:
TELEPHONE NUMBER:		

You must attach proof of coverage from your insurance carrier or letter from employer verifying coverage with the above-named carrier.

Acceptable Proof of Other Acceptable Coverage	Not Acceptable Proof
• Proof of Coverage letter/certificate from the insurance carrier with a current date (may be printed from the carrier's website or on letterhead) • Medicare Card • Letter from employer stating employee is currently covered under the employer's plan • Front and back copy of current Military ID	• Insurance Card • Explanation of Benefits Documentation (EOB) • Paystub

NOTICE: Eligible employees who decline coverage due to other acceptable coverage and then lose their other coverage must immediately notify the unit and enroll in the Local Government Health Insurance Plan. Coverage will be effective the date the other acceptable coverage ended. If the unit does not notify Local Gov of the loss of other acceptable coverage and does not enroll the employee in the LGHIP, the unit will be responsible for any premiums due and will be billed retroactively to the date the eligible employee should have been enrolled (i.e. the date the other acceptable coverage ended).

Full-time Date of Hire:	**Employee Signature:**
Local Government Unit Name:	
Unit Number:	**Date:**
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:	

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