

**LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
MEMBER INFORMATION CHANGES FORM**

PARTICIPANT INFORMATION (Please print or type.)

Name (First, Middle Initial, Last) _____	Social Security Number _____
Select the change that needs to be made from the options below:	
☐ MAILING ADDRESS _____ Street Address or Post Office Box City _____ State _____ Zip _____	
☐ PARTICIPANT'S / ☐ DEPENDENT'S NAME* From: _____ To: _____ <i>*Documentation Required</i>	
☐ PARTICIPANT'S / ☐ DEPENDENT'S DATE OF BIRTH From: _____ To: _____ <i>*Documentation Required</i>	
☐ PARTICIPANT'S / ☐ DEPENDENT'S SOCIAL SECURITY NUMBER: _____ <i>*Documentation Required</i>	
☐ TELEPHONE NUMBER: Primary (_____) _____ Work: (_____) _____	
☐ E-MAIL ADDRESS _____	
Other Group Health Insurance Information	
Do you have additional insurance coverage other than LGHIP coverage? ☐ Yes ☐ No If yes, you must complete Other Group Health Insurance Addendum	
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 the Local Gov's behalf.	
_____ Participant Signature	_____ Date
TO BE COMPLETED BY EMPLOYER	
Requested Effective Date of Change: _____ Unit Name: _____ Unit Number: _____ <i>*LGHIP may revise this date without notifying the unit if the requested date is incorrect</i>	
If signed electronically, I acknowledge and certify the electronic signature process complies with the Alabama Uniform Electronic Transaction Act and the Local Gov's rules outlined in the Administrative Guide.	
Signature of Benefit Administrator: _____ Date: _____	

Must be completed if you, your spouse and/or dependents have any other coverage.

[illegible][illegible]