Form LG09
Revised 8/23

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	☐ Vision and Dental

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: 01/01/2024 **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 LGHIB rules outlined in the Administrative Guide.

Signature of Benefit Administrator: ____ **Date:** __________________

LOCAL GOVERNMENT HEALTH INSURANCE BOARD
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