

## LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM CANCELLATION FORM

**PARTICIPANT INFORMATION** (Please print or type)

Name (First, Middle Initial, Last)	Social Security Number
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**CANCEL ALL INSURANCE COVERAGE FOR THE FOLLOWING REASONS:**

Participant's signature is not required for the following cancel reasons:

- Termination \_\_\_\_\_  Voluntary  Involuntary  
Last Day in Pay Status
- Reduction of hours to less than 30 hours per week
- Declination of Coverage \_\_\_\_\_  
Name of Insurance Company  
Name of Employer (if applicable)
- Military Leave Date \_\_\_\_\_ Attach military papers.
- Leave Without Pay - Non-Payment \_\_\_\_\_
- Death \_\_\_\_\_  
Date of Death
- Retirement Date \_\_\_\_\_ Unit does not allow retiree coverage
- Date Retiree became eligible for Medicare \_\_\_\_\_ Unit does not allow Medicare Coverage
- Retiree Non-Payment \_\_\_\_\_ COBRA **will not** be offered.  
 For Medicare retirees, the Unit affirms it has provided the retiree with CMS 21-day notice of disenrollment
- Other \_\_\_\_\_ Date \_\_\_\_\_

COBRA will not be offered if terminated due to gross misconduct

Must provide proof of other acceptable coverage. Cannot submit copy of insurance card as proof.

**Participant's signature is required to cancel coverage for the following reasons:**

- Retiree Requested Cancellation \_\_\_\_\_
- Other \_\_\_\_\_ Date \_\_\_\_\_

For units that provide retiree coverage, the following must be completed:

- Retirement Date \_\_\_\_\_
- Employee is eligible for and was offered LGHIP retiree health insurance coverage but declined

**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 coverage will be cancelled.

\_\_\_\_\_ Participant Signature

\_\_\_\_\_ Date

**TO BE COMPLETED BY EMPLOYER**

Requested Effective Date of Cancellation\*: \_\_\_\_\_ Unit Name: \_\_\_\_\_ Unit Number: \_\_\_\_\_  
 \*LGHIP may revise this date without notifying the unit if the requested date is incorrect

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

Signature of Benefit Administrator: \_\_\_\_\_ Date: \_\_\_\_\_