Form LG02-C
Revised 8/22

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
DEPENDENT CANCELLATION FORM

PARTICIPANT INFORMATION (Please print or type.)

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

DROP DEPENDENT COVERAGE (Must select one)

☐ Change from Family to Single Coverage ☐ Cancel dependent(s) listed below from Family Coverage

REASON FOR CANCEL- Must select one reason for cancelling dependent coverage.
If requesting to drop a dependent outside of Open Enrollment, proof of the qualifying event must be submitted.
Death is the only exception to this policy.

	MONTH/DAY/YEAR		MONTH/DAY/YEAR
☐ Death	_____	☐ Dependent no longer resides in household/ Dependent has a change of address	_____
☐ Divorce Attach divorce decree	_____	☐ Dependent obtained employment	_____
☐ Loss of custody Attach court documents	_____	☐ Open Enrollment	Effective January 1, 2023
☐ Medicare/Medicaid entitlement	_____	☐ Dependent employed by a unit in the LGHIP	_____
☐ Retirement of Participant	_____	Name of Unit: _____	
☐ Significant change of premiums / benefits	_____	☐ Other Qualifying Event	_____
		Explain	_____

First Name	Initial	Last Name	Relationship to Participant: (Spouse, Son, Daughter, Stepson, Stepdaughter, Male or Female Custodial Dependent)	Date of Birth	Social Security Number

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 and acknowledge that only eligible dependents may be covered under the Local Government Health Insurance Plan and I will be personally responsible for all claims for ineligible dependents.

_____ Participant Signature

_____ Date

TO BE COMPLETED BY EMPLOYER

Requested Effective Date of Change: _____ **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 LGHIB rules outlined in the Administrative Guide.

Signature of Benefit Administrator: _____ **Date:** _____

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