Form LG03
Revised 8/22

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
CANCELLATION FORM

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

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

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
☐ Terminated due to gross misconduct
COBRA will not be offered if terminated due to gross misconduct

☐ Reduction of hours to less than 30 hours per week

☐ Declination of Coverage ____
Name of Insurance Company
____
Name of Employer (if applicable)
Must provide proof of other acceptable coverage. Cannot submit copy of insurance card as proof.

☐ 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 ___________________________

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 LGHIB rules outlined in the Administrative Guide.

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

LOCAL GOVERNMENT HEALTH INSURANCE BOARD
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