Form LG02
Revised 9/24

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: _____

**Documentation Required*

☐ PARTICIPANT'S / ☐ DEPENDENT'S DATE OF BIRTH From: _____ To: _____

☐ 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:** _____
**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's rules outlined in the Administrative Guide.

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

LOCAL GOV HEALTH AND WELLNESS
(334) 851-6802 • 1-866-836-9137
enrollments@lghip.org

Other Group Health Insurance Addendum

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

LIST EACH INSURANCE COMPANY SEPARATELY (ATTACH ADDITIONAL SHEETS IF NECESSARY)			
Name of Contract Holder	Contract Holder Date of Birth	Group #	Insurance Contract #
Name of Insurance Company		Types of coverage (Check all that apply) ☐ Hospitalization ☐ Doctor's Visits ☐ Prescription Drugs ☐ Dental	
Name of Employer			
If other coverage includes prescription drug coverage, please complete the below (information can be found on your other coverage insurance card)			
Rx BIN Number	Rx ID		

Are you or any of your dependents covered on this insurance policy? ☐ Yes (list each covered individual below) ☐ No

Name(s) (First, Middle Name, Last)	Date of Birth	Coverage Effective Date(s)

LIST EACH INSURANCE COMPANY SEPARATELY (ATTACH ADDITIONAL SHEETS IF NECESSARY)			
Name of Contract Holder	Contract Holder Date of Birth	Group #	Insurance Contract #
Name of Insurance Company		Types of coverage (Check all that apply) ☐ Hospitalization ☐ Doctor's Visits ☐ Prescription Drugs ☐ Dental	
Name of Employer			
If other coverage includes prescription drug coverage, please complete the below (information can be found on your other coverage insurance card)			
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Are you or any of your dependents covered on this insurance policy? ☐ Yes (list each covered individual below) ☐ No

Name(s) (First, Middle Name, Last)	Date of Birth	Coverage Effective Date(s)