

## LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM DEPENDENT CANCELLATION FORM

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

Name (First, Middle Initial, Last)	Social Security Number
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**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
<input type="checkbox"/> Death	_____	<input type="checkbox"/> Dependent no longer resides in household/ Dependent has a change of address		_____
<input type="checkbox"/> Divorce Attach divorce decree	_____	<input type="checkbox"/> Dependent obtained employment		_____
<input type="checkbox"/> Loss of custody Attach court documents	_____	<input type="checkbox"/> Open Enrollment		<u>Effective January 1, 2025</u>
<input type="checkbox"/> Medicare/Medicaid entitlement	_____	<input type="checkbox"/> Spouse employed by a unit in the LGHIP		_____
<input type="checkbox"/> Retirement of Participant	_____	Name of Unit: _____		
<input type="checkbox"/> Significant change of premiums / benefits	_____	<input type="checkbox"/> 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 Local Gov rules outlined in the Administrative Guide.

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