Form LG02
Revised 8/18

**FOR LGHIB USE ONLY**
Date: _____
Initials: _____

# LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
# 2019 STATUS CHANGE FORM

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

| Name (First, Middle Initial, Last) | | | Date of Birth |
|---|---|---|---|
| Social Security Number | Contract Number | Home Telephone Number ( ) | Work Telephone Number ( ) Ext. |

CHANGE: ☐ MAILING ADDRESS To: _____
Street Address or Post Office Box

_____
City State Zip

☐ SUBSCRIBER'S NAME From: _____ To: _____

☐ DEPENDENT'S NAME From: _____ To: _____

☐ SUBSCRIBER'S DATE OF BIRTH From: _____ To: _____

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

☐ TELEPHONE NUMBER To: Home (_____)_____Work: (_____)_____

☐ E-MAIL ADDRESS To: _____

CHANGE RATE: ☐ Retired Subscriber (Not Medicare Participant)
☐ Dependent not Medicare ☐ Dependent Medicare

CHANGE RATE: ☐ Retired Subscriber (Medicare Participant)
☐ Dependent not Medicare ☐ Dependent Medicare

**Note:** If in your rate above you selected: ☒ **Retired Subscriber (Medicare Participant)** or ☒ **Dependent Medicare,** you must provide a copy of your Red, White, and Blue Medicare Card.

## AFFIRMATION AND RELEASE

**I understand and acknowledge that only eligible dependents may be added to my coverage. An ex-spouse and ex-stepchildren are ineligible for coverage and cannot be maintained as dependents under my family coverage regardless of a judgment or divorce decree requiring me to provide health care for my ex-spouse or ex-stepchildren. I understand and acknowledge that an ex-spouse and ex-stepchildren must be removed from coverage effective the first day of the month following the date of the divorce decree and it is my responsibility to notify the LGHIB immediately when the eligibility of a covered dependent changes. If it is determined that an act on my part (such as adding an ineligible person to coverage) or omission (such as failing to remove a person no longer eligible for coverage) results in or contributes to the payment of claims for persons ineligible for coverage, I will be personally responsible for all such overpayments and may be subject to disqualification from coverage under the plan.**

**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 insurance 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 LGHIB's behalf.**

_____ _____
**Employee Signature** **Date**

## TO BE COMPLETED BY EMPLOYER

**Effective Date of Change:** _____

**Local Government Unit Name:** _____ **Account Number:** _____

**Signature of Insurance Clerk:** _____ **Date:** _____

**LOCAL GOVERNMENT HEALTH INSURANCE BOARD**
**POST OFFICE BOX 304900**
**MONTGOMERY, ALABAMA 36130-4900**
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