Form LG02
Revised 10/20

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
2021 STATUS CHANGE FORM

FOR LGHIB USE ONLY
Date: _____
Initials: _____

SUBSCRIBER INFORMATION (Please print or type.)

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

Select the change that needs to be made from the options below:

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

_____
City State Zip

☐ SUBSCRIBER'S NAME From: _____ To: _____

☐ DEPENDENT'S NAME* From: _____ To: _____
**Documentation Required*

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

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

☐ TELEPHONE NUMBER: Primary (_____) _____ Work: (_____) _____

☐ E-MAIL ADDRESS To: _____

Retirement
Check applicable boxes

Retiree: ☐ Not Medicare ☐ Medicare
☐ Retired due to Social Security Disability (provide disability determination letter)
☐ Retired based upon years of service (must provide form LG22)

Dependent: ☐ Not Medicare ☐ Medicare

Physical address of Medicare retirees must be provided.

_____
Physical Street Address

_____
City State Zip

Note: If in the section above you selected: ☒ **Retiree: Medicare** or ☒ **Dependent: Medicare,** you must provide a copy of your Red, White and Blue Medicare Card and a physical address. Your name must match the name listed on your 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

Requested Effective Date of Change: _____
**LGHIP may revise this date without notifying the unit if the requested date is incorrect*

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

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