

FOR LGHIB USE ONLY
Date: _____
Initials: _____

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM 2016 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: _____

E-MAIL ADDRESS To: _____

CHANGE RATE: <input type="checkbox"/> Retired Subscriber (Not Medicare Participant) <input type="checkbox"/> Dependent not Medicare <input type="checkbox"/> Dependent Medicare	CHANGE RATE: <input type="checkbox"/> Retired Subscriber (Medicare Participant) <input type="checkbox"/> Dependent not Medicare <input type="checkbox"/> Dependent Medicare
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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.

<p style="text-align: center;">TO BE COMPLETED BY EMPLOYER</p> <p>Effective Date of Change: _____</p> <p>_____</p> <p style="text-align: center;">Local Government Unit Name</p> <p>_____</p> <p style="text-align: center;">Account Number</p> <p>_____</p> <p>Signature of Insurance Clerk Date</p>	<p style="text-align: center;">AFFIRMATION AND RELEASE</p> <p>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.</p> <p>_____</p> <p style="text-align: center;">Employee Signature Date</p>
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