

FOR LGHIB USE ONLY

Date: _____

Initials: _____

**LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
2016 CANCELLATION FORM**

SUBSCRIBER INFORMATION (Please print or type.)

Name (First, Middle Initial, Last)		Date of Birth
Social Security Number	Contract Number	

CANCEL ALL INSURANCE COVERAGE FOR THE FOLLOWING REASONS:

- _____ Voluntary Termination _____
Last Day in Pay Status _____
- _____ Involuntary Termination _____
Last Day in Pay Status _____
- _____ Retirement Date _____
- _____ Retiree Non-Payment _____ COBRA **will not** be offered.
- _____ Military Leave Date _____ Attach military papers.
- _____ Death _____
- _____ Leave Without Pay - non-payment _____
- _____ Other Date _____ Give explanation: _____
- _____ Declination of Coverage. (You MUST complete and submit a "Declination of Coverage" form.)

Note: By submitting this Cancellation Form, health insurance coverage will be terminated.

TO BE COMPLETED BY EMPLOYER	AFFIRMATION AND RELEASE
Effective Date of Cancellation: _____	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.
Local Government Unit Name _____	
Account Number _____	
Signature of Insurance Clerk _____ Date _____	
Employee Signature _____ Date _____	

**LOCAL GOVERNMENT HEALTH INSURANCE BOARD
POST OFFICE BOX 304900
MONTGOMERY, ALABAMA 36130-4900
334.263.8326 / 1.866.836.9137 / FAX: 334.517.9778**