

**LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
2016 DECLINATION OF COVERAGE FORM**

FOR LGHIB USE ONLY
Date: _____
Initials: _____

SUBSCRIBER INFORMATION (Please print or type.)

Name (First, Middle Initial, Last)		Sex	Date of Birth
Social Security Number	Contract Number	Home Telephone Number () ()	Work Telephone Number () ()
Mailing Address	City	State	Zip Code

I, _____, wish to decline coverage in the Local Government Health Insurance Program. I affirm that I currently have other group health insurance coverage* through _____.

(name of local government employee) *(name of employer/company)*

My other insurance carrier is:

NAME OF INSURANCE COMPANY:		
ADDRESS:		
CITY:	STATE:	ZIP CODE:
TELEPHONE NUMBER:		

*** You must attach a current letter from employer/insurance carrier verifying coverage with the above- named carrier. A copy of your insurance card IS NOT acceptable as proof of coverage.**

Employee Status: Full-time Employee Elected Official

NOTICE:

Under the Health Insurance Portability and Accountability Act, the LGHIP must offer a special enrollment period in addition to open enrollment for those employees who experience a qualifying event such as loss of their other employer group coverage or the addition of a dependent. However, since the LGHIP already requires that an employee enroll in the plan when they lose other employer group coverage, special enrollment will only apply to the following qualifying events not related to loss of coverage:

- the addition of a new dependent through birth, adoption or marriage or
- a substantial change in their other employer group coverage or
- a substantial change in the cost of their other employer group coverage.

All employees who lose their other employer group coverage, whether voluntarily or involuntarily must submit an enrollment form to the LGHIB with coverage effective as of the date coverage is lost.

To be eligible for special enrollment an employee must submit a declination of coverage form with proof of other employer group coverage. Persons requesting special enrollment must notify the LGHIB in writing within 30 days of the qualifying event.

Notification must include:

1. a letter requesting participation in the special enrollment; and
2. a completed enrollment form; and
3. if proof of the qualifying event is not submitted with the letter requesting special enrollment and the completed enrollment form, the proof listing the reason and date of loss for all individuals affected by loss of coverage (e.g., employment termination on company letterhead) must be submitted within 60 days of the qualifying event.

Full-time Date of Hire:	Employee Signature:
Local Government Unit Name:	
Account Number:	Date:
Signature of Insurance Clerk:	