Form LG01
Revised 9/16

FOR LGHIB USE ONLY
Date _____
Initials: _____

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
2017 ENROLLMENT FORM

SUBSCRIBER INFORMATION (Please print or type.)

Name (First, Middle Initial, Last)				Sex
Social Security Number			Date of Birth	
Mailing Address		City	State	ZIP Code
Home Telephone Number	Work Telephone Number		E-mail Address:	

Employment Status (Check One)

☐ Full-time Employee	☐ ACA Eligible (Must submit documentation)	☐ Elected Official	☐ Retired (Not Medicare Participant)	☐ Retired (Medicare Participant)

Note: If your Employment Status above is ☒ **Retired**, and you or your covered dependent(s) are covered by Medicare, you must provide a copy of your Red, White, and Blue Medicare Card.

NOTE: BY LISTING FAMILY MEMBERS BELOW YOU ARE APPLYING FOR AND REQUESTING FAMILY COVERAGE.

First Name Initial Last Name	Documentation is required. See back of form. Relationship to Employee		Date of Birth	Social Security Number
	☐ Male Spouse	☐ Female Spouse		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Grandson ☐ Nephew	☐ Granddaughter ☐ Niece		
	☐ Grandson ☐ Nephew	☐ Granddaughter ☐ Niece		

TO BE COMPLETED BY EMPLOYER

Probationary Period: Yes _____ No _____

If yes to above: Start Date _____ End Date _____

Full-time date of hire:

Local Government Unit Name

Account Number

Signature of Insurance Clerk **Date**

AFFIRMATION AND RELEASE

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**

Dependent documentation is required before dependents can be added to coverage.

GENERAL INFORMATION

Eligible Dependent

(**Appropriate documentation must be attached.)**

The term "dependent" includes the following individuals subject to appropriate documentation such as a Social Security number, marriage certificate, birth certificate, court decree, etc.

1. Your spouse (excludes divorced spouse).
2. A child under age 26, only if the child is:
   a. your son or daughter. (A court decree establishing paternity will be temporarily effective for 60 days, at which time an amended birth certificate listing the father's name will be due.)
   b. a child legally adopted by you or your spouse,
   c. your stepchild,
3. Your grandchild, niece or nephew
   a. under 19 years of age, and
   b. for whom the court has granted custody to you or your spouse
4. An incapacitated dependent over age 25 will be considered for coverage provided dependent:
   a. is unmarried,
   b. is permanently mentally or physically disabled or incapacitated,
   c. is so incapacitated as to be incapable of self-sustaining employment,
   d. is dependent upon you for 50% or more financial support,
   e is otherwise eligible for coverage as a dependent except for age,
   f. the condition must have occurred prior to the dependent's 26th birthday, and
   g. is not eligible for any other group health insurance benefits.

Neither a reduction in work capacity nor inability to find employment is, of itself, evidence of eligibility. If a mentally or physically disabled dependent is working, despite his disability, the extent of his earning capacity will be evaluated.

To apply, contact the LGHIB to obtain an Incapacitated Dependent Certification Form. Final approval of incapacitation will be determined by Medical Review. Proof of disability must be provided to the LGHIB within 60 days from the date the child would cease to be covered because of age.

Exception: There are two situations under which it may be possible to add an incapacitated dependent who otherwise meets the eligibility requirements except for age:

1. When a new employee requests coverage for an incapacitated dependent within 60 days of employment; or
2. When an employee's incapacitated dependent is covered under a spouse's employer group health insurance for at least 18 consecutive months and:
   a. the employee's spouse loses the other coverage because:
      - spouse's employer ceases operations, or
      - spouse's loss of eligibility due to termination of employment or reduction of hours of employment, or
      - spouse's employer stopped contribution to coverage,
   b. a change form is submitted to the LGHIB within 30 days of the incapacitated dependent's loss of other coverage, and
   c. Medical Review approved incapacitation status.

The above requirements must be met as a minimum threshold in order to be considered for incapacitation status. The LGHIB shall make the final decision as to whether an application for incapacitated status will be accepted.

NOTE: The LGHIB reserves the right to periodically re-certify incapacitation.

Exclusion: You may not cover your spouse or other dependents if they are insured or if they are eligible to be insured as an active employee in the Local Government Health Insurance Program.

LOCAL GOVERNMENT HEALTH INSURANCE BOARD
POST OFFICE BOX 304900
MONTGOMERY, ALABAMA 36130-4900
(334) 263-8326 | 1-866-836-9137 | FAX: (334) 517-9778

Discrimination is Against the Law

The Local Government Health Insurance Board (LGHIB) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The LGHIB does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The LGHIB:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact 1-855-216-3144 or TTY: 711.

If you believe that the LGHIB has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Section 1557 Coordinator, 201 South Union Street, Montgomery, Alabama, 36104; Direct: (334) 263-8402; Fax (334) 263-8711; Email: 1557Grievance@lghip.org. You can file a grievance by mail, fax, email or in person. If you need help filing a grievance, the Section 1557 Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Multi-Language Interpreter Services

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-216-3144 (TTY: 711).

Korean: 주의: 만약 당신이 말하는 스페인어, 당신은 당신의 처리 무료 언어 지원 서비스에 있다. 전화는 1-855-216-3144 (TTY: 711).

Chinese: 注意： 如果讲西班牙语，有免费的援助语言及其处置服务。调用 1-855-216-3144 (TTY: 711)。

Vietnamese: Chú ý: Nếu bạn nói tiếng Tây Ban Nha, bạn có lúc xử lý ngôn ngữ miễn phí dịch vụ hỗ trợ của bạn. Gọi đến 1-855-216-3144 (TTY: 711).

Arabic: تنبيـــــه: إذا كـان يتحـــدث الإســـــبانية، وفـــي التخلـــص من خـدماتها المســـاعدة بالمســـاعدة اللغويـــة. إلــى الـدعوة 1-855-216-3144 (TTY: 711).

German: Achtung: Wenn Sie Spanisch sprechen, müssen Sie Ihre kostenlose Hilfe Serviceleistungen zur Verfügung. Aufruf an die 1-855-216-3144 (TTY: 711).

French: ATTENTION : Si vous parlez espagnol, vous avez à votre disposition linguistique gratuite assistance services. Appel à la 1-855-216-3144 (ATS : 711).

Gujarati: ચુના: જો તમે જરાતી બોલતા હો, તો િ ન:લ્કુ ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છ. ફોન કરો 1-1-855-216-3144 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-216-3144 (TTY: 711).

Hindi: ध्यान दें: यदि स्पेनिश बोलते हैं, अपने निपटान पर सेवाओं की भाषाई सहायता नि: शुल्क है। 1-855-216-3144 कॉल (TTY: 711)।

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວ ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫ ຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-216-3144 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на испанском языке, вы имеете в вашем распоряжении бесплатные помощи услуги. Вызовите 1-855-216-3144 (TTY: 711).

Portuguese: Atenção: Se fala espanhol, tem em seus serviços de eliminação de assistência linguística. Ligue para o 1-855-216-3144 (TTY: 711).

Turkish: Dikkat: İspanyolca, elden çıkarma ücretsiz dil yardım hizmetlerinde varsa. Aramak için 1-855-216-3144 (TTY: 711).

Japanese: 注意: あなたがスペイン語を話す場合、あなたはあなたの処分無料言語アシスタンスサ―ビスでありま. 1-855-216-3144 を呼び出す (TTY: 711)