

**LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM  
2022 ENROLLMENT FORM**

**EMPLOYEE INFORMATION (Please print or type)**

Name (First, Middle Initial, Last)		Social Security Number	Date of Birth	Gender
Mailing Address		City	State	ZIP Code
Physical Address *Must be completed by Medicare Retiree Enrollee		City	State	ZIP Code
Primary Phone Number	Work Phone Number	E-mail Address:		

**Employment Status (Check One)**

<input type="checkbox"/> Full-time Employee	<input type="checkbox"/> ACA Eligible <small>(Must submit Form LG23)</small>	<input type="checkbox"/> Elected Official	<input type="checkbox"/> Retired (Not Medicare Participant)	<input type="checkbox"/> Retired (Medicare Participant)
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**Employee declines LGHIP health insurance coverage but would like to enroll in Southland Voluntary Coverage**   
If declining LGHIP health insurance coverage, a completed Declination of Coverage form must be submitted.

**Note:** If you or your covered dependent(s) are covered by Medicare, you must submit 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.

**Dependent Information - Documentation is required before dependents can be added to coverage. See back of form.**

Dependent's Name (First, Middle, Last)	Relationship to Employee (Male or Female Spouse, Son, Daughter, Stepson, Stepdaughter, Male or Female Custodial Dependent)	Date of Birth	Social Security Number	Coverage Check all that apply
				BCBS <input type="checkbox"/> Southland <input type="checkbox"/>
				BCBS <input type="checkbox"/> Southland <input type="checkbox"/>
				BCBS <input type="checkbox"/> Southland <input type="checkbox"/>
				BCBS <input type="checkbox"/> Southland <input type="checkbox"/>
				BCBS <input type="checkbox"/> Southland <input type="checkbox"/>
				BCBS <input type="checkbox"/> Southland <input type="checkbox"/>

**Southland Voluntary Coverage**

A minimum enrollment of 12 months is required for employees and dependents without a qualifying event.  
Premiums listed below are separate from LGHIP health insurance coverage.

<p align="center"><b>Southland Vision</b></p> <p><input type="checkbox"/> Single \$12 per month</p> <p><input type="checkbox"/> Family \$20 per month (complete dependent section above)</p> <p>Effective Date of Coverage: _____</p>	<p align="center"><b>Southland Dental</b></p> <p><input type="checkbox"/> Single \$44 per month</p> <p><input type="checkbox"/> Family \$44 per month (complete dependent section above)</p> <p>Effective Date of Coverage: _____</p>
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**Other Group Health Insurance Information**

Do you have additional insurance coverage other than LGHIP coverage?  Yes  No  
If yes, you must complete the Other Group Health Insurance Addendum on Page 3.

**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 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 LGHIP's behalf.

I understand and acknowledge that only eligible dependents may be added to my coverage. I understand and acknowledge that it is my responsibility to notify the LGHIP 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.

\_\_\_\_\_

**Employee Signature**

\_\_\_\_\_

**Date**

**TO BE COMPLETED BY EMPLOYER**

**Full-Time Date of Hire:** \_\_\_\_\_ **Local Government Unit Name:** \_\_\_\_\_ **Unit Number:** \_\_\_\_\_

If signed electronically, I acknowledge and certify the electronic signature process complies with the Alabama Uniform Electronic Transaction Act and the LGHIP rules outlined in the Administrative Guide.

**Signature of Benefit Administrator:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# GENERAL INFORMATION

## Eligible Dependent

### (Appropriate documentation must be attached.)

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

- The participant's spouse (excludes a divorced spouse)
- A child under age 26, only if the child is:
  - The participant's son or daughter
  - A child legally adopted by the participant or their spouse
  - The participant's stepchild
- A dependent, under age 19, for whom the participant, or his or her spouse, has been granted legal and physical custody by a court of competent jurisdiction
- An incapacitated child\* over age 25 will be considered for coverage provided the dependent child is:
  - unmarried,
  - permanently mentally or physically disabled or incapacitated,
  - so incapacitated as to be incapable of self-sustaining employment,
  - dependent upon the participant for 50% or more financial support,
  - otherwise eligible for coverage as a dependent child except for age,
  - had the condition prior to the child's 26th birthday, and
  - not eligible for any other group insurance benefits.

\*The above requirements must be met to be eligible for coverage as an incapacitated child. The LGHIB will decide whether an application for incapacitated status will be accepted and final approval of incapacitation will be determined by medical review conducted by BCBS. The LGHIB reserves the right to periodically recertify incapacitation. Neither a reduction in work capacity nor inability to find employment is, of itself, evidence of eligibility. If a mentally or physically incapacitated child is employed, the extent of their earning capacity will be evaluated.

See the "Enrolling an Incapacitated Child" section for critical enrollment deadlines. If deadlines are not met, coverage may be denied.

## Ineligible Dependents

An individual who does not meet the definition of an eligible dependent shall not be allowed to be covered as a dependent under the LGHIP. Examples include, but are not limited to:

- A participant's spouse or other dependents if they are independently eligible for coverage as an employee of a participating unit
- An ex-spouse, regardless of what the divorce decree may state
- Ex-stepchildren, regardless of what the divorce decree may state
- Children age 26 and older
- Foster children
- Incapacitated children age 26 and older who do not meet the Incapacitated Child eligibility requirements
- A child of a dependent child
- A participant's child, if the child has been adopted by someone other than their spouse and the participant has been relieved of their parental rights and responsibilities
- A daughter-in-law or son-in-law
- Grandchildren or other individuals related to the participant by blood or marriage for which the participant does not have legal custody
- Grandchildren or other children age 19 and older regardless of whether the participant has legal custody
- Grandparents
- Parents
- A fiancé or live-in girlfriend or boyfriend

## Enrolling an Incapacitated Child

To apply, contact the LGHIB to obtain an Incapacitated Child Certification form. A completed Incapacitated Child Certification form and proof of incapacity must be provided to the LGHIB no more than 60 days after the dependent's 26th birthday\*. If the form and proof of incapacity is not submitted within the required time, the child is not eligible for future enrollment except in the following two situations:

- When a new participant requests coverage for an incapacitated child within 60 days of employment; or
- When a participant's incapacitated child is covered under a spouse's employer group health insurance for at least 18 consecutive months and:
  - the spouse loses the other coverage because:
    - the employer ceases operations, or
    - of termination of employment or reduction of hours of employment, or
    - the employer stopped contributing to coverage.

In these two situations, the child must meet all the Incapacitated Child eligibility requirements and submit an Incapacitated Child Certification form and a New Dependent form to the LGHIB within 60 days of the incapacitated child's loss of other coverage. The LGHIB will decide whether an application for incapacitated status will be accepted and final approval of incapacitation will be determined by medical review conducted by BCBS.

\*The 60-day time limit does not apply to enrollment in a Southland Voluntary Plan.

