Form LG11
Revised 10/21

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM

Local Government Unit			Unit #
Mailing Address	City	State	ZIP Code
Physical Address	City	State	ZIP Code

Unit Contacts

Health Insurance Administrator	Title
Phone Number	Email Address
Primary Contact (If Different)	Title
Phone Number	Email Address
Additional Contact (If Different)	Title
Phone Number	Email Address
Additional Contact (If Different)	Title
Phone Number	Email Address
Wellness Contact (If Different)	Title
Phone Number	Email Address
Physical Address	City / State / ZIP Code
Delete Contact	

Updates to Coverage

Submit during Open Enrollment for a January 1 effective date

Dental Coverage for all employees	☐ Add	☐ Drop
Coverage for Non-Medicare Retirees	☐ Add	☐ Drop
Coverage for Medicare Retirees	☐ Add	☐ Drop
Coverage for Elected Officials	☐ Add	☐ Drop
Effective Date of Coverage	☐ Date of Hire	☐ 1st Day of 2nd Month

_____ Name of Benefit Administrator

_____ Title

_____ Signature

_____ Date