

2010 CANCELLATION FORM LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM

SUBSCRIBER INFORMATION

Name (First, Middle Initial, Last)	Sex	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 (_____/_____/_____)

_____ Military Leave Date (_____/_____/_____) Attach military papers.

_____ Other Date (_____/_____/_____) Give explanation: _____

_____ Declination of Coverage. You MUST complete a "Declination of Coverage" form.

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 SEIB's behalf.
_____ Local Government Unit Name	
_____ Account Number	
_____ Signature of Insurance Clerk	
_____ Date	_____ Employee Signature
	_____ Date

STATE EMPLOYEES' INSURANCE BOARD
POST OFFICE BOX 304900
MONTGOMERY, ALABAMA 36130-4900
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