2010 DECLINATION OF COVERAGE FORM
LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM

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

I, ______________________________, wish to decline coverage in the Local Government Health
(name of local government employee)

Insurance Program. I affirm that I currently have other group health insurance coverage* through ______________________.
(name of employer/company)

My other insurance carrier is:

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

**** You must attach a certificate of creditable coverage or 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 SEIB 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 SEIB within 30 days of a qualifying event. Notification should include:

a. letter requesting participation in the special enrollment;
b. a completed enrollment form;
c. proof of a qualifying event; and
d. a Certificate of Creditable Coverage.

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

STATE EMPLOYEES' INSURANCE BOARD
POST OFFICE BOX 304900
MONTGOMERY, ALABAMA 36130-4900
334.263.8326 / 1.866.836.9137 / FAX: 334.263.8526