

**LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM**

**General Information**

This Application is: \_\_\_\_\_ Initial Enrollment  
\_\_\_\_\_ Revised Enrollment Information

Federal ID Number \_\_\_\_\_

Name \_\_\_\_\_

Address for Billing \_\_\_\_\_

Street Address or P. O. Box

Street Address or P. O. Box

City

State

ZIP Code

County

Prior Insurance Carrier \_\_\_\_\_

Health Insurance Administrator \_\_\_\_\_

Position/Title \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Unit E-Mail Address \_\_\_\_\_

Contact Person for Billing \_\_\_\_\_

Position/Title \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Unit E-Mail Address \_\_\_\_\_

Additional Contact Person \_\_\_\_\_

Form Completed By: \_\_\_\_\_ Date \_\_\_\_\_

**FOR SEIB USE ONLY. DO NOT WRITE IN THIS SPACE.**

**GROUP ENTITY NO.** \_\_\_\_\_ **DATE** \_\_\_\_\_

**EFFECTIVE DATE** \_\_\_\_\_ **DENTAL** \_\_\_\_\_

**RETIREEES (NON-MEDICARE)** \_\_\_\_\_ **(MEDICARE)** \_\_\_\_\_

**NEW HIRES** \_\_\_\_\_

**ELECTED OFFICIALS** \_\_\_\_\_