State of Illinois
Department of Central Management Services

LOCAL GOVERNMENT HEALTH PLAN
Correction/Change Form

Member Name: _____ Member SSN: _____

Unit Name: _____

Employee Termination

Date: _____ Reason: _____

Termination will be effective at midnight of the date of termination. *(Attach documentation, if applicable.)*

Change in Contact Information

Date Effective: _____ ☐ Member ☐ Dependents

New Address: _____

New Phone: _____ New E-mail: _____

Qualifying Change in Status (select one) **Month/Day/Year**

- ☐ Birth/adoption/legal custody/adjudicated child – *attach documentation*
- ☐ Marriage, *attach copy of marriage license*
  Change Name to: _____
- ☐ Divorce/annulment/legal separation – *attach documentation*
  Change Member Name to: _____
- ☐ Member's Employment Status: Part-time to Full-time
- ☐ Member's Employment Status: Full-time to Part-time
- ☐ Member going on Leave of Absence
- ☐ Spouse gains employment/Group Insurance Coverage
- ☐ Spouse loses employment/Loses other coverage
- ☐ Spouse's premium increases 30% or greater or significantly decreases coverage/Member's premium increases 30% or greater
- ☐ Coordination of Spouse's Annual Election Period
- ☐ Change in Member/Spouse/Dependent's County of Residence or County of Work Location
- ☐ Current HMO network unavailable
- ☐ Change in Medicaid status
- ☐ Change in Medicare status – *complete* ***Medicare Status*** *section below*
- ☐ Member's employment status changes: Active to Annuitant
- ☐ Waived Employee loses other coverage
- ☐ Military Call-Up
- ☐ Other[1]
  [1]Explain: _____

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Unit Name: _____

Qualifying Change in Status Required Action

- ☐ Add Member: *complete enrollment forms*
- ☐ Add Dependent(s): *complete a dependent enrollment form for each dependent and attach required documentation*
- ☐ Drop Dependent(s): Reason: _____

  Dependent Name: _____ SSN: _____

  Dependent Name: _____ SSN: _____

  Dependent Name: _____ SSN: _____

  Dependent Name: _____ SSN: _____

- ☐ COBRA Effective Date: _____

Medicare Status: (check one) - Attach a copy of Medicare card(s)

- ☐ 1. Medicare Eligible 65+
- ☐ 2. Medicare Disability
- ☐ 3. End Stage Renal Disease
- ☐ 4. Medicare Ineligible

Complete the following:

Part A (begin date) _____

Part B (begin date) _____

Part D (begin date) _____

Part A Free ☐ Yes ☐ No

Additional Comments/Other

Member Signature: _____ Date: _____

*Note: Change in Status **requires** Member's Signature*

Health Plan Representative Signature: _____ Date: _____

Health Plan Representative Phone Number: _____

Attachments: (documentation) _____

Date sent to LGHP: _____

Mail to: LGHP
801 South 7th Street
Springfield, Illinois 62703

Fax to: 217-524-7541