MEMO

From: **Kristin Tyson**
Subject: **New Hire Orientation**

You are scheduled for Orientation with Kristin Tyson at the Houston County Personnel building (501 North Foster Street). Please have the following information with you....

- Social Security Card
- Driver's License
- Direct Deposit- Voided Check OR TYPED memo from your bank listing the routing and account number

If you are a ***full-time employee*** you will need the following in addition to what is listed above:

- Beneficiaries Date of Birth, Address and Social Security Number

If you are going to add any family members to your benefits, you will also need the following information....

Social Security Card for each person
Birth Certificate for each child
Marriage Certificate (if applicable)

If you plan to DECLINE coverage, please bring a **letter of creditable coverage** from your current health insurance provider. It MUST have the current date, policy number, and your name as a dependent. They DO NOT accept insurance cards as proof.

The attached paperwork must be turned in the first day of employment in order for personnel to prepare documents for orientation. Once completed, please email them to kltyson@houstoncountyal.gov

_____ Insurance _____ Vision _____ Employee Number

_____ Cafeteria _____ Dept # _____ Grade

_____ Direct Deposit _____ Job Code _____ Step

_____ Flex _____ Pay _____ OT

HOUSTON COUNTY PERSONAL DATA SHEET

NAME: _____ SEX: ☐ Male ☐ Female

RACE:
- ☐ White
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ American Indian or Alaska Native
- ☐ Two or More Races

Address: _____ (Street)

_____ (City State Zip Code)

Social Security #: _____

Birthdate: _____

Email Address: _____

Cell # : _____

Other # : _____

Marital Status (Circle One):
Married Single

PERSON TO BE CONTACTED IN CASE OF EMERGENCY:

Name: _____ Home/Cell Phone: _____

Address: _____ Work Phone: _____

_____

Relationship: _____

List any medical condition(s) or prescription(s) used regularly which could be noted in emergency situations: _____

_____

List any physical disabilities: _____

_____

Signature **Date**

For Personnel Department Use Only:

EMPLOYMENT DATE: _____ JOB TITLE: _____

DEPARTMENT: _____

☐ AS400 ☐ Insurance ☐ Pay Card ☐ Safety

Form LG01
Revised 9/24

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
ENROLLMENT FORM

EMPLOYEE INFORMATION (Please print or type)

Name (First, Middle Initial, Last)		Social Security Number	Date of Birth	Gender
Mailing Address		City	County	State / ZIP Code
Physical Address *Must be completed by Medicare Retiree Enrollee		City	County	State / ZIP Code
Primary Phone Number	Work Phone Number	Email Address:		

Employment Status (Check One)

☑ Full-time Employee	☐ ACA Eligible (Must submit Form LG23)	☐ Elected Official	☐ Retired (Not Medicare Participant)	☐ Retired (Medicare Participant)

Note: If you or your covered dependent(s) are covered by Medicare, you must submit a copy of your Red, White, and Blue Medicare Card and a physical address. Your name must match the name listed on your Medicare card.

Dependent Information - Documentation is required before dependents can be added to coverage. See back of form.

Dependent's Name (First, Middle, Last)	Relationship to Employee (Male or Female Spouse, Son, Daughter, Stepson, Stepdaughter, Male or Female Custodial Dependent)	Date of Birth	Social Security Number

Other Group Health Insurance Information

Do you have additional insurance coverage other than LGHIP coverage? ☐ Yes ☐ No

If yes, you must complete the Other Group Health Insurance Addendum on Page 3.

AFFIRMATION AND RELEASE

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 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 Local Gov's behalf.

I understand and acknowledge that only eligible dependents may be added to my coverage. I understand and acknowledge that it is my responsibility to notify Local Gov immediately when the eligibility of a covered dependent changes. If it is determined that an act on my part (such as adding an ineligible person to coverage) or omission (such as failing to remove a person no longer eligible for coverage) results in or contributes to the payment of claims for persons ineligible for coverage, I will be personally responsible for all such overpayments and may be subject to disqualification from coverage under the plan.

_____ _____

Employee Signature **Date**

TO BE COMPLETED BY EMPLOYER

Full-Time Date of Hire: _____ **Local Government Unit Name:** _____ **Unit Number:** _____

If signed electronically, I acknowledge and certify the electronic signature process complies with the Alabama Uniform Electronic Transaction Act and Local Gov rules outlined in the Administrative Guide.

Signature of Benefit Administrator: _____ **Date:** _____

Local Gov Health and Wellness
(334) 851-6802 • 1-866-836-9137
Enrollments@lghip.org