COMMONWEALTH OF KENTUCKY
PERSONNEL CABINET
DEPARTMENT FOR EMPLOYEE INSURANCE

HEALTH INSURANCE UPDATE FORM

Do NOT use this form to add or drop dependents. Insurance Coordinator complete form.

GENERAL INFORMATION (*REQUIRED*)

SOCIAL SECURITY NUMBER	COMPANY NUMBER
NAME	COMPANY NAME

TERMINATION: DATE EMPLOYMENT ENDS ______________________ DATE INSURANCE TERMINATES ______________________

Reason: Resigned Retired LWOP Death Military Other ______________________

REINSTATE: DATE RETURNED TO WORK ______________________ DATE INSURANCE EFFECTIVE ______________________

Reason: Rehired FMLA LWOP Military Other ______________________

TRANSFER

- *To be completed by the NEW company*
- *No changes to current coverage are allowed on this form*

PRIOR COMPANY # ______________________	NEW COMPANY # ______________________
LAST DATE WORKED AT PRIOR COMPANY ______________________	DATE HIRED AT NEW COMPANY ______________________
COVERAGE END DATE FROM PRIOR COMPANY # ______________________	COVERAGE BEGIN DATE AT NEW COMPANY # ______________________

OTHER CHANGES OR CORRECTIONS FOR SELF ☐ SPOUSE ☐ CHILD ☐

NAME NEW ______________________

PREVIOUS ______________________

NEW ADDRESS (where mail received) ______________________

CITY: ______________________ STATE: ______________________ ZIP CODE: ______________________

EMAIL: ______________________

SSN CORRECT ______________________ INCORRECT ______________________

DATE OF BIRTH ______________________ OTHER ______________________

EMPLOYEE SIGNATURE	DATE	COORDINATOR SIGNATURE	DATE

Insurance Coordinator: Mail this form to DEI, 501 High St., 2nd Floor, Frankfort, KY 40601