Kentucky Employees' Health Plan
Department of Employee Insurance
Kehp.ky.gov • 1.888.581.8834

2018 EMPLOYEE HEALTH INSURANCE ENROLLMENT/CHANGE APPLICATION

Section 1: To Be Completed by IC/HRG – IN OFFICE USE ONLY

KHRIS Personnel Number	Organizational Unit #	Company Name	Hire/Transfer/Term Date	Coverage Effective Date	Company #	Cost Center #

Note: Verification documents may be required; refer to the Administration Manual.

Reason(s) for Application:
- ☐ New Hire
- ☐ Rehire
- ☐ New Group
- ☐ Qualifying Event
- ☐ Change or Update
- ☐ ACA
- ☐ Grievance

Change in Employee Status:
- ☐ Transfer
- ☐ Begin LWOP
- ☐ End LWOP
- ☐ Begin Military Leave
- ☐ End Military Leave
- ☐ Retired
- ☐ Termination

Qualifying Event:
- ☐ Marriage
- ☐ Birth/Adoption/Placement
- ☐ Court Order for Child
- ☐ Divorce
- ☐ Death
- ☐ Loss of Individual Health
- ☐ Loss of Group Health
- ☐ Begin Medicare/Medicaid
- ☐ End Medicare/Medicaid
- ☐ Spouse/Dependent Starting Employment
- ☐ Spouse/Dependent Terminating Employment
- ☐ Other:

Termination or transfer
If transfer: This is to be completed by the **NEW** company & no changes to current coverage allowed.

Prior Company #:

Last Day worked:

Coverage End date:

Section 2: Demographic Information Changes or Current (Circle one)

Employee's SSN	Employee Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	Home County Code

Street Address		Primary Phone #	Work Email Address
City, State Zip	County	Secondary Phone #	Home Email Address
Sex: ☐Male ☐Female		Married: ☐Yes ☐No	

Section 3: Spouse Information Changes or Current (Circle one)

Spouse's SSN	Spouse's Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	☐Add ☐ Drop ☐Remain	Sex ☐Male ☐ Female

☐ I wish to utilize the cross-reference payment option (two KEHP members, married with children – no LRP or JRP).

Spouse's Personnel Number	Spouse's Organizational Unit #	Spouse's Company #

Spouse's Phone #	Spouse's Home Email Address	Spouse's Work Email Address

Section 4: Dependent Information Changes or Current (Circle one)

Child #1 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	☐Male ☐Female ☐Disabled Dependent	☐Add ☐ Drop ☐Remain
Child #2 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	☐Male ☐Female ☐Disabled Dependent	☐Add ☐ Drop ☐Remain
Child #3 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	☐Male ☐Female ☐Disabled Dependent	☐Add ☐ Drop ☐Remain

Employee: **Employee SSN:**

Child #4 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	☐Male ☐Female ☐Disabled Dependent	☐Add ☐ Drop ☐Remain
Child #5 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	☐Male ☐Female ☐Disabled Dependent	☐Add ☐ Drop ☐Remain
Child #6 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	☐Male ☐Female ☐Disabled Dependent	☐Add ☐ Drop ☐Remain

Section 5: Tobacco Use Declaration Rules governing the Tobacco Use Declaration can be found in your Benefits Selection Guide or at kehp.ky.gov. You are eligible for the non-tobacco user premium contribution rates provided you certify that you or any other person to be covered under your plan has not regularly used tobacco within the past six months.

Planholder: Within the past 6 months, have you used tobacco regularly?
☐Yes ☐No
Has your spouse, if covered under this plan, used tobacco regularly within the past 6 months?
☐Yes ☐No
Have any children covered under this plan, age 18 or older, used tobacco regularly within the past 6 months?
☐Yes ☐No

Section 6: Coverage Level

☐ Single (self only) ☐ Parent Plus (self and child(ren)) ☐ Couple (self and spouse) ☐ Family (self, spouse and child(ren))

Section 7: Plan Options

☐ LivingWell CDHP ☐ I agree to the LivingWell Promise. Instructions on fulfilling your Promise can be found at LivingWell.ky.gov.
☐ LivingWell PPO ☐ I agree to the LivingWell Promise. Instructions on fulfilling your Promise can be found at LivingWell.ky.gov.
☐ Standard PPO
☐ Standard CDHP
☐ Waiver (General Purpose) HRA – with $ (I declare that I and, if applicable, my spouse and my dependents, have other group health plan coverage that provides minimum value. To the extent applicable, I have listed my spouse and all dependents whose medical expenses can be reimbursed under the HRA in Sections 3 and 4 of this application.)
My Group Health Plan Carrier:________________ **My Group Health Plan Policy Number:**________________
☐ Waiver Dental/Vision ONLY HRA – with $
☐ Waiver without HRA – No $
☐ Default Standard PPO – IC/HRG use ONLY

Section 8: Signatures – Please submit this application to your Company IC/HRG By signing this application, I certify that the information provided in this application is true and correct to the best of my knowledge. I also certify that I have read, understand and agree to the Terms and Conditions of participation in the KEHP, the KEHP Legal Notices, and the Tobacco Use Declaration. These documents can be found in your Benefits Selection Guide or online at kehp.ky.gov.

By typing my name in the space provided below, I am signing this application electronically and am agreeing to conduct this transaction by electronic means.

Employee Signature | Spouse Signature – REQUIRED if electing cross-reference | Date

IC/HRG Signature | IC/HRG Printed Name | Date | IC/HRG Phone #

Spouse's IC/HRG Signature – REQUIRED if electing cross-reference | Spouse's IC/HRG Printed Name | Date | Spouse's IC/HRG Phone #