Name: ____ Request Date: ____

Employed by: ____

Beginning Date			Ending Date			Part-time or Full-time Status	Positions Held	Days per Year
Mo.	Da.	Yr.	Mo.	Da.	Yr.			

Continuing Contract Status: ☐ Yes ☐ No **(MUST BE COMPLETED)**

Transferring Sick Days ____ **(MUST BE COMPLETED)**

Open Record Request: Please provide any information contained in this individual's personnel record evidencing any disciplinary action taken while he/she was employed by your district/agency.

☐ Information enclosed/attached ☐ No disciplinary action on record for this individual

TRANSFERS ONLY - Health Insurance / HRA / FSA

Company # ____ Pers Number ____ KRS/TRS Contriution Group ____

Plan Options		***Coverage Level***		***Waiving Health Insurance***	
LivingWell CDHP	☐	Single	☐	Waiver (General Purpose with HRA $	☐
LivingWell PPO	☐	Parent Plus	☐	Waiver Dental/Vision ONLY HRA with $	☐
LivingWell Basic CDHP	☐	Couple	☐	No HRA - without $	☐
LivingWell High Ded	☐	Family	☐		

Employee Montly Premium ____ Last Day Worked ____

Cross Reference ____ Tobacco Use ☐ Termination of Health Coverage ____

FSA **(monthly deduction):** ____ Dependent Care Acct **(monthly deduction)** ____

Anthem Dental Monthly Premium ____ Anthem Vision Monthly Premium ____

Dental Term Date ____ Vision Term Date ____

TRANSFERS ONLY - State Group Life Insurance (MetLife)

Optional Life and Accidental Death				***Dependent Life Insurance***					
$10,000	☐	$100,000	☐	Option 1 ($8.18)	☐	Option 4 ($6.54)	☐	Option 7 ($2.70)	☐
$25,000	☐	$150,000	☐	Option 2 ($16.34)	☐	Option 5 ($13.04)	☐	Option 8 ($5.40)	☐
$50,000	☐		☐	Option 3 ($35.90)	☐	Option 6 ($32.60)	☐		☐

Other Voluntary Deductions

Deductions	***Amount Per Month***	***Date Coverage Ends***

Name/Title/Phone# of Person Completing form: ____

Signature: ____ Date: ____

Revised 7/2023