

DO NOT STAPLE

2025 EMPLOYEE BENEFITS ENROLLMENT/CHANGE FORM

Section 1: To be completed by the IC/HRG – IN OFFICE USE ONLY

KHRIS Personnel #	Organizational Unit # 10006144	Cost Center # 9200100501	Company Name Pulaski County Bd of Ed	Company # 00501	Coverage Effective Date	Hire/QE/Transfer/Term Date		
Reason(s) for Application: <input type="checkbox"/> New Hire <input type="checkbox"/> Rehire/Reinstate <input type="checkbox"/> New Group <input type="checkbox"/> Qualifying Event <input type="checkbox"/> Change or Update <input type="checkbox"/> ACA <input type="checkbox"/> Exception <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Update Demographics		Change in Employee Status: <input type="checkbox"/> Transfer <input type="checkbox"/> Begin LWOP <input type="checkbox"/> End LWOP <input type="checkbox"/> Begin Military Leave <input type="checkbox"/> End Military Leave <input type="checkbox"/> Retired <input type="checkbox"/> Termination <input type="checkbox"/> Summer Transfer		Qualifying Event: <input type="checkbox"/> Marriage <input type="checkbox"/> Birth/Adoption/Placement <input type="checkbox"/> Court Order for Child <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Loss of Individual Health <input type="checkbox"/> Loss of Group Health <input type="checkbox"/> Begin Medicare/Medicaid <input type="checkbox"/> End Medicare/Medicaid <input type="checkbox"/> Sp/Dep Start Employment <input type="checkbox"/> Sp/Dep Termed Employment <input type="checkbox"/> Other: _____			Transfer from one KEHP covered entity to another KEHP covered entity: This section is to be completed by the NEW company & no changes to current coverage allowed. Prior Agency #: _____ Last Day Worked: _____	

Section 2: Employee Information

Employee's SSN	Employee Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)
Mailing Address	City, State Zip	County
Primary Phone #	Secondary Phone #	Email Address-Preferably Work Email
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Married: <input type="checkbox"/> Yes <input type="checkbox"/> No	Anthem Dental <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain Anthem Vision <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain

Section 3: Spouse Information

Spouse's SSN	Spouse's Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Health <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain Dental <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain Vision <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain		
<input type="checkbox"/> I wish to utilize the cross-reference payment option (two members, married with children). Not available for new hires hired on or after 1/1/2025.			
Spouse's Personnel Number	Spouse's Hire Date	Spouse's Organizational Unit #	Spouse's Company #
Spouse's Primary Phone #	Spouse's Secondary Phone #	Spouse's Email Address-Preferably Work Email	

Section 4: Dependent Information

Child #	SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	Gender	Health	Dental	Vision
Child #1	SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Disabled Dependent	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain
Child #2	SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Disabled Dependent	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain
Child #3	SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Disabled Dependent	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain
Child #4	SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Disabled Dependent	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain
Child #5	SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Disabled Dependent	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain
Child #6	SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Disabled Dependent	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain
Child #7	SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Disabled Dependent	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain

Employee:

Employee SSN:

Section 5: Tobacco Use Declaration Rules governing the Tobacco Use Declaration can be found online at keh.p.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: Health Insurance Plan Options-All plans require the LivingWell Promise to receive the monthly premium discount of \$40 for the next plan year. Instructions and more information on fulfilling the LivingWell Promise can be found at keh.p.ky.gov in the Benefits Selection Guide.

LivingWell CDHP LivingWell PPO LivingWell Basic CDHP LivingWell High Deductible Health Plan

Select a Health Premium Level Single (self only) Parent Plus (self + child(ren)) Couple (self and spouse) Family (self, spouse and child(ren))

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.)

Source of other coverage: Covered w/my spouse’s employer (does not include TRICARE) Covered w/my parent’s employer Dual group coverage/my own 2nd employer/retirement plan

***Note: if you have Medicaid, Medicare, TRICARE, Christian Healthcare Ministry, Veteran’s Benefits or Individual Coverage w/Marketplace/Exchange, you are not eligible for the Waiver GP HRA but can elect the Waiver Limited Purpose HRA.**

Waiver Limited Purpose HRA – with \$

Waiver without HRA – No \$

Default Waiver w/o HRA (no HRA funds) – IC/HRG use ONLY – This should be used when a NEW HIRE does not submit an enrollment form or enroll online with KHRIS ESS.

Section 7: Anthem Dental Insurance Options

Dental Bronze Dental Silver Dental Gold

Select a Dental Premium Level

Single (self only) Parent Plus (self + child(ren))

Couple (self and spouse) Family (self, spouse and child(ren)) *If cross-reference, please list the employee to carry the coverage _____*

Section 8: Anthem Vision Insurance Options

Vision Bronze Vision Silver Vision Gold

Select a Vision Premium Level

Single (self only) Parent Plus (self + child(ren))

Couple (self and spouse) Family (self, spouse and child(ren)) *If cross-reference, please list the employee to carry the coverage _____*

Section 9: Flexible Spending Accounts

Healthcare Flexible Spending Account

I request to (check one) Enroll in or Change my Healthcare FSA for calendar year 2025. I understand that the minimum allowable contribution is \$10 per month (\$5 per semi-monthly period).

Total Calendar Year Contribution; divisible by 24: \$ _____

If cross-ref, please list the amount for each employee:

Employee Name: _____ Amount: _____

Employee Name: _____ Amount: _____

*New hires should calculate year contribution from effective date to the end of the year.

- Maximum calendar year contribution is \$3,200 per eligible Planholder.
- Minimum calendar year contribution is \$120 (or \$10 per month).
- Maximum annual carryover amount is \$640 from 2025 to 2026.
- Minimum annual carryover amount is \$50.

Child and Adult Daycare Flexible Spending Account

I request to (check one) Enroll in or Change my Child and Adult Daycare FSA for calendar year 2025. I understand that the minimum allowable contribution is \$10 per month (\$5 per semi-monthly period).

Total Calendar Year Contribution; divisible by 24: \$ _____

If cross-ref, please list the amount for each employee:

Employee Name: _____ Amount: _____

Employee Name: _____ Amount: _____

*New hires should calculate year contribution from effective date to the end of the year.

- Maximum contribution per tax filing status is \$2,500 married filing separately, \$5,000 married filing, or \$5,000 married head of household.
- Minimum calendar year contribution is \$120 (or \$10 per month).
- For daycare expenses such as preschool, summer day camp, before/after school programs, and child or elder daycare.

Section 10: 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 online at keh.p.ky.gov and extranet.personnel.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	IC/HRG Phone#
Spouse’s IC/HRG Signature-REQUIRED if electing cross-reference	Spouse’s IC/HRG Printed Name	IC/HRG Phone#
		Date