

DO NOT STAPLE



2026 EMPLOYEE BENEFITS ENROLLMENT/CHANGE FORM

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

KHRIS Personnel #	Organizational Unit #	Cost Center #	Company Name	Company Number	Coverage Effective Date	Hire/QE/Transfer/Term Date
Reason(s) for Application:		Change in Employee Status:		Qualifying Event:		
<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		<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		<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	

Race/Ethnicity Data: The Commonwealth of Kentucky does not discriminate on the basis of race, color, religion, sex, national origin, sexual orientation, gender identity or expression, ancestry, age, pregnancy or related medical condition, marital or familial status, disability, veteran status, political affiliation, or genetic information, in accordance with state and federal laws. **Completion of the questions below is OPTIONAL and will NOT affect the terms or conditions of your medical coverage or your eligibility for medical coverage.** The federal government strongly encourages employers and health plans to collect social data about individuals to better identify environmental and personal conditions that affect a wide range of health and quality-of-life outcomes. **This data will be kept private and used only to help the Commonwealth of Kentucky better understand how to provide healthcare services to you.** Please select the one category with which you identify:

- Hispanic or Latino White (Non-Hispanic or Latino) Black or African American (Non-Hispanic or Latino) Asian (Non-Hispanic or Latino) Native Hawaiian or Other Pacific Islander (Non-Hispanic or Latino) American Indian or Alaska Native (Non-Hispanic or Latino) Two or More Races Prefer Not to Answer

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 Primary Phone #	Spouse's Secondary Phone #	Spouse's Email Address-Preferably Work Email

Employee:

Employee SSN:

Section 4: Dependent Information				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

Section 5: Tobacco Use Declaration Rules governing the Tobacco Use Declaration can be found online 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: 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 kehp.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.

