Department of Employee Insurance
Kehp.ky.gov Personnel.ky.gov 888-581-8834
DO NOT STAPLE

TEAM KENTUCKY PERSONNEL CABINET | Department of Employee Insurance

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
	10006166	9200100571	Warren Co Schools	00571		

Reason(s) for Application:
- ☐ New Hire
- ☐ Rehire/Reinstate
- ☐ New Group
- ☐ Qualifying Event
- ☐ Change or Update
- ☐ ACA
- ☐ Exception
- ☐ Open Enrollment
- ☐ Update Demographics

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

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
- ☐ Sp/Dep Start Employment
- ☐ Sp/Dep Termed Employment
- ☐ 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: ☐Male ☐Female	Married: ☐Yes ☐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: ☐Male ☐ Female	**Health** ☐Add ☐ Drop ☐Remain **Dental** ☐Add ☐ Drop ☐Remain **Vision** ☐Add ☐ Drop ☐Remain	

☐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	

Employee: **Employee SSN:**

Section 4: Dependent Information				**Health**	**Dental**	**Vision**
Child #1 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	☐ Male ☐ Female ☐ Disabled Dependent	☐Add ☐Drop ☐Remain	☐Add ☐Drop ☐Remain	☐Add ☐Drop ☐Remain
Child #2 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	☐ Male ☐ Female ☐ Disabled Dependent	☐Add ☐Drop ☐Remain	☐Add ☐Drop ☐Remain	☐Add ☐Drop ☐Remain
Child #3 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	☐ Male ☐ Female ☐ Disabled Dependent	☐Add ☐Drop ☐Remain	☐Add ☐Drop ☐Remain	☐Add ☐Drop ☐Remain
Child #4 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	☐ Male ☐ Female ☐ Disabled Dependent	☐Add ☐Drop ☐Remain	☐Add ☐Drop ☐Remain	☐Add ☐Drop ☐Remain
Child #5 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	☐ Male ☐ Female ☐ Disabled Dependent	☐Add ☐Drop ☐Remain	☐Add ☐Drop ☐Remain	☐Add ☐Drop ☐Remain
Child #6 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	☐ Male ☐ Female ☐ Disabled Dependent	☐Add ☐Drop ☐Remain	☐Add ☐Drop ☐Remain	☐Add ☐Drop ☐Remain
Child #7 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	☐ Male ☐ Female ☐ Disabled Dependent	☐Add ☐Drop ☐Remain	☐Add ☐Drop ☐Remain	☐Add ☐Drop ☐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.

Employee: **Employee SSN:**

Section 7: Anthem Dental Insurance Options	**Section 8: Anthem Vision 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* _____	☐ 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

New Hire: ☐ I request to **enroll** in an FSA. I understand that the minimum allowable contribution is $10 per month ($5 per semi-monthly period).

Note: All three fields must be completed for each elected FSA.	Contribution Per Paycheck	Number of Paychecks Remaining in Plan Year		Your Annual Election Amount
Healthcare FSA	$ _____	X (multiply) _____	=	$ _____
Child & Adult Daycare FSA	$ _____	X (multiply) _____	=	$ _____

If cross-ref, please list the amount for each employee for Healthcare FSA:
*Employee Name:*_____ *Amount:*_____
*Employee Name:*_____ *Amount:*_____

If cross-ref, please list the amount for each employee for Child & Adult Daycare FSA:
*Employee Name:*_____ *Amount:*_____
*Employee Name:*_____ *Amount:*_____

Qualifying Event (QE): ☐ I request to enroll in an FSA or change my contribution amount for the remainder of the year. I understand that the minimum allowable contribution is $10 per month ($5 per semi-monthly period). NOTE: If you decrease the election amount due to a QE, it cannot be less than what you have used or contributed already.

Note: All three fields must be completed for each elected FSA.	Contribution Per Paycheck	Number of Paychecks Remaining in Plan Year		New Election Amount from the Effective Date
Healthcare FSA	$ _____	X (multiply) _____	=	$ _____
Child & Adult Daycare FSA	$ _____	X (multiply) _____	=	$ _____

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 kehp.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
	Sherry Stratton	270-781-5150	
IC/HRG Signature	IC/HRG Printed Name	IC/HRG Phone#	Date
Spouse's IC/HRG Signature-REQUIRED if electing cross-reference	Spouse's IC/HRG Printed Name	IC/HRG Phone#	Date