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

DO NOT STAPLE

2019 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/QE/Transfer/Term Date	Coverage Effective Date	Company #	Cost Center #

Reason(s) for Application:
- ☐ Open Enrollment
- ☐ 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:
☐ Healthcare FSA	☐ Dependent Care FSA
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)	IC/HRG Name

Street Address		Primary Phone #	Email Address - preferably Work Email for notification purposes
City, State Zip	County	Secondary Phone #	
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 Hire Date	Spouse's Organizational Unit #	Spouse's Company #

Spouse's Phone #	Spouse's Email Address - preferably Work Email for notification purposes	IC/HRG Name

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 - Note: Verification documents may be required; check with your Insurance Coordinator or HR office.

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

Section 7: Plan Options – All plans require the LivingWell Promise to receive the monthly premium discount for the next plan year. Instructions on fulfilling your Promise can be found at LivingWell.ky.gov.

☐ LivingWell CDHP
☐ LivingWell PPO
☐ LivingWell Basic CDHP
☐ LivingWell Limited High Deductible
☐ 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 LivingWell Limited High Deductible – 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 #