

**DO NOT STAPLE**

**2019 EMPLOYEE HEALTH INSURANCE ENROLLMENT/CHANGE APPLICATION**

<b>Section 1: To Be Completed by IC/HRG – IN OFFICE USE ONLY</b>															
KHRIS Personnel Number	Organizational Unit #	Company Name	Hire/QE/Transfer/Term Date	Coverage Effective Date	Company #	Cost Center #									
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%; padding: 5px; vertical-align: top;"> <b>Reason(s) for Application:</b>  <input type="checkbox"/> Open Enrollment  <input type="checkbox"/> New Hire  <input type="checkbox"/> Rehire  <input type="checkbox"/> New Group  <input type="checkbox"/> Qualifying Event  <input type="checkbox"/> Change or Update  <input type="checkbox"/> ACA  <input type="checkbox"/> Grievance                 </td> <td style="width:15%; padding: 5px; vertical-align: top;"> <b>Change in Employee Status:</b>  <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                 </td> <td style="width:20%; padding: 5px; vertical-align: top;"> <b>Qualifying Event:</b>  <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                 </td> <td style="width:20%; padding: 5px; vertical-align: top;"> <input type="checkbox"/> Begin Medicare/Medicaid  <input type="checkbox"/> End Medicare/Medicaid  <input type="checkbox"/> Spouse/Dependent Starting Employment  <input type="checkbox"/> Spouse/Dependent Terminating Employment  <input type="checkbox"/> Other:                 </td> <td style="width:30%; padding: 5px; vertical-align: top;"> <b>Termination or Transfer</b>                      If transfer: This is to be completed by the <b>NEW</b> company &amp; no changes to current coverage allowed.  <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; padding: 5px;">Prior Company #:</td> <td style="width:50%; padding: 5px;">Last Day worked:</td> </tr> <tr> <td style="padding: 5px;"><input type="checkbox"/> Healthcare FSA</td> <td style="padding: 5px;"><input type="checkbox"/> Dependent Care FSA</td> </tr> </table>                     Coverage End date:                 </td> </tr> </table>							<b>Reason(s) for Application:</b> <input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire <input type="checkbox"/> Rehire <input type="checkbox"/> New Group <input type="checkbox"/> Qualifying Event <input type="checkbox"/> Change or Update <input type="checkbox"/> ACA <input type="checkbox"/> Grievance	<b>Change in Employee Status:</b> <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	<b>Qualifying Event:</b> <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"/> Spouse/Dependent Starting Employment <input type="checkbox"/> Spouse/Dependent Terminating Employment <input type="checkbox"/> Other:	<b>Termination or Transfer</b> If transfer: This is to be completed by the <b>NEW</b> company & no changes to current coverage allowed. <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; padding: 5px;">Prior Company #:</td> <td style="width:50%; padding: 5px;">Last Day worked:</td> </tr> <tr> <td style="padding: 5px;"><input type="checkbox"/> Healthcare FSA</td> <td style="padding: 5px;"><input type="checkbox"/> Dependent Care FSA</td> </tr> </table> Coverage End date:	Prior Company #:	Last Day worked:	<input type="checkbox"/> Healthcare FSA	<input type="checkbox"/> Dependent Care FSA
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<b>Section 2: Demographic Information -- Changes or Current (Circle one)</b>															
Employee's SSN	Employee Name (Last, First, MI)		Date of Birth (mm/dd/yyyy)		Home County Code										
Street Address			Primary Phone #		Email Address - preferably Work Email for notification purposes										
City, State Zip		County Code		Secondary Phone #											
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female			Married: <input type="checkbox"/> Yes <input type="checkbox"/> No												
<b>Section 3: Spouse Information -- Changes or Current (Circle one)</b>															
Spouse's SSN	Spouse's Name (Last, First, MI)		Date of Birth (mm/dd/yyyy)		<input type="checkbox"/> Add <input type="checkbox"/> Drop	Sex									
					<input type="checkbox"/> Remain	<input type="checkbox"/> Male <input type="checkbox"/> Female									
<input type="checkbox"/> 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												
<b>Section 4: Dependent Information -- Changes or Current (Circle one)</b>															
Child #1 SSN	Name (Last, First, MI)		Date of Birth (mm/dd/yyyy)		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Add <input type="checkbox"/> Drop									
					<input type="checkbox"/> Disabled Dependent	<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"/> Add <input type="checkbox"/> Drop									
					<input type="checkbox"/> Disabled Dependent	<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"/> Add <input type="checkbox"/> Drop									
					<input type="checkbox"/> Disabled Dependent	<input type="checkbox"/> Remain									

**Employee:****Employee SSN:**

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
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
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

**Section 5: Tobacco Use Declaration** Rules governing the Tobacco Use Declaration can be found in your Benefits Selection Guide or at [kehp.ky.gov](http://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](http://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](http://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 #