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

TEAM KENTUCKY PERSONNEL CABINET | Department of Employee Insurance

2025 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 #	Coverage Effective Date	Hire/QE/Transfer/Term Date

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	**Anthem Dental** ☐Add ☐ Drop ☐Remain **Anthem Vision** ☐Add ☐ Drop ☐Remain

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**	

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

Employee: **Employee SSN:**

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.

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 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

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