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

2018 RETIREE HEALTH INSURANCE QUALIFYING EVENT FORM

Section 1: To Be Completed by Insurance Coordinator

KHRIS Personnel Number	Hazardous Duty ☐	Date of Retirement	Qualifying Event Date	Coverage Effective Date

☐ KRS 80000 10006416	☐ TRS 85000 10006418	☐ KCTCRS 81000 10006417	☐ JRP 86000 10006419	☐ LRP 87000 10006420

KRS Only:	☐ KRS - KERS	☐ CERS – Oth.Ag	☐ KRS - SPRS

Deletion of Dependent		Addition of Dependent	
☐ Divorce ☐ Death ☐ Loss of Eligibility	☐ Gaining Other Coverage ☐ Gaining Medicare/Medicaid ☐ Other ----------	☐ Marriage ☐ Birth/Adoption ☐ Guardianship/Court Order	☐ Loss of Other Coverage ☐ Loss of KCHIP/Medicaid ☐ Re-establishing Eligibility ☐ Special Enrollment

Section 2: Demographic Information

Retiree's SSN	Retiree's Name (Last, First, MI)	Retiree's Date of Birth

Applicant's SSN	Applicant's Name (Last, First, MI)	Applicant's Date of Birth

Street Address	Primary Phone #	Secondary Phone #

City, State Zip	County	Home Email Address

Sex: ☐Male ☐Female | Married: ☐Yes ☐No

Are you Medicare eligible due to Social Security disability? ☐Yes ☐No

Section 3: Spouse Information – Skip to Section 5 if electing single coverage

Spouse's SSN	Spouse's Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	Sex ☐Male ☐ Female

Is Spouse Medicare eligible due to Social Security disability? ☐Yes ☐No

☐ I wish to utilize the Cross reference payment option (two KEHP members, married with children – no LRP or JRP).

KRS Only:	☐ KRS - KERS	☐ CERS – Oth.Ag	☐ KRS - SPRS

Spouse's Date of Hire/Retirement	Spouse's Organizational Unit #	Spouse's Company #

Spouse's Home Email Address	Spouse's Work Email Address

Section 4: Dependent Information (must include dependent verification documents)

Are any Dependents Medicare eligible due to Social Security Disability? ☐ Yes ☐ No

If yes, who?

Child #1 SSN	Name (Last, First, MI)	☐ Natural ☐ Adopted ☐ Court Ordered ☐ Foster ☐ Step ☐ Disabled	Date of Birth	☐Male ☐Female	☐Tobacco User
Child #2 SSN	Name (Last, First, MI)	☐ Natural ☐ Adopted ☐ Court Ordered ☐ Foster ☐ Step ☐ Disabled	Date of Birth	☐Male ☐Female	☐Tobacco User
Child #3 SSN	Name (Last, First, MI)	☐ Natural ☐ Adopted ☐ Court Ordered ☐ Foster ☐ Step ☐ Disabled	Date of Birth	☐Male ☐Female	☐Tobacco User
Child #4 SSN	Name (Last, First, MI)	☐ Natural ☐ Adopted ☐ Court Ordered ☐ Foster ☐ Step ☐ Disabled	Date of Birth	☐Male ☐Female	☐Tobacco User
Child #5 SSN	Name (Last, First, MI)	☐ Natural ☐ Adopted ☐ Court Ordered ☐ Foster ☐ Step ☐ Disabled	Date of Birth	☐Male ☐Female	☐Tobacco User

Retiree's SSN:	Applicant's SSN:

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

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

Section 7: Plan Options

☐ LivingWell CDHP
☐ LivingWell PPO
☐ Standard PPO
☐ Standard CDHP
☐ Default Standard PPO – INSURANCE COORDINATOR USE ONLY
☐ Waive Coverage, No HRA – without $ Reason for Waiving: _____

Section 8: LivingWell Promise (required for selecting a LivingWell Plan)

☐ I agree to the LivingWell Promise. Electing a LivingWell Promise plan in 2018 means you are required to complete either the Go365 Health Assessment (HA) or biometric screening from January 1, 2018 through July 1, 2018. Instructions on fulfilling your Promise can be found at LivingWell.ky.gov.

Section 9: Signatures – Please submit this application to your Company Insurance Coordinator

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/Retiree Signature Date

_____ _____
Applicant Signature Date

_____ _____
Spouse Signature – REQUIRED if electing the cross-reference payment option Date

_____ _____
IC/HRG Signature Date

_____ _____
IC/HRG Printed Name IC/HRG Phone Number

_____ _____
Spouse's IC/HRG Signature – REQUIRED if electing the cross-reference payment option Date

_____ _____
Spouse's IC/HRG Printed Name Spouse's IC/HRG Phone Number