TEACHERS' RETIREMENT SYSTEM
of the State of Kentucky

GARY L. HARBIN, CPA
*Executive Secretary*

ROBERT B. BARNES, JD
*Deputy Executive Secretary*
*Operations and General Counsel*

J. ERIC WAMPLER, JD
*Deputy Executive Secretary*
*Finance and Administration*

**MEMORANDUM**

TO: TRS Retirees

FROM: TRS Insurance Department

RE: Adding Dependents

Outside of open enrollment, retirees may be allowed to add a spouse and/or dependents to their plan if a qualifying event (QE) has occurred and the required form is signed within 35 days, except for birth, adoption, and loss of Medicaid (see accompanying QE chart).

If a qualifying event has occurred, you should complete the attached Retiree Health Insurance Qualifying Event Form and return it with the required verification and QE documentation (see accompanying charts).

If documentation is required and not provided, your application cannot be processed. Please review the QE chart and sign the form appropriately to avoid double coverage or a lapse in coverage. The form must be signed no later than the deadline mentioned above.

If you have any questions, please contact our office.

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 | ☐ Gaining Other Coverage | ☐ Marriage | ☐ Loss of Other Coverage |
| ☐ Death | ☐ Gaining Medicare/Medicaid | ☐ Birth/Adoption | ☐ Loss of KCHIP/Medicaid |
| ☒ Loss of Eligibility | ☐ Other _____ | ☐ Guardianship/Court Order | ☐ 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 ☐ Foster ☐ Adopted ☐ Step ☐ Court Ordered ☐ Disabled | Date of Birth | ☐Male ☐Female | ☐Tobacco User |
| Child #2 SSN | Name (Last, First, MI) | ☐ Natural ☐ Foster ☐ Adopted ☐ Step ☐ Court Ordered ☐ Disabled | Date of Birth | ☐Male ☐Female | ☐Tobacco User |
| Child #3 SSN | Name (Last, First, MI) | ☐ Natural ☐ Foster ☐ Adopted ☐ Step ☐ Court Ordered ☐ Disabled | Date of Birth | ☐Male ☐Female | ☐Tobacco User |
| Child #4 SSN | Name (Last, First, MI) | ☐ Natural ☐ Foster ☐ Adopted ☐ Step ☐ Court Ordered ☐ Disabled | Date of Birth | ☐Male ☐Female | ☐Tobacco User |
| Child #5 SSN | Name (Last, First, MI) | ☐ Natural ☐ Foster ☐ Adopted ☐ Step ☐ Court Ordered ☐ 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

# QUALIFYING EVENT (QE) CHART WITH DOCUMENTATION REQUIREMENTS TO ADD/ENROLL

*Rev 8/2018*

| Event | Allowed Changes | Event Date | Signature Deadline | Effective Date | DOCUMENTS REQUIRED |
|---|---|---|---|---|---|
| **CHANGE IN LEGAL MARITAL STATUS** | | | | | |
| Marriage | - Add Retiree, Spouse and/or Dependent(s) including Tag-Alongs [16] | Date of the marriage | 35 calendar days from the Event Date | First of the month following signature date | 1 (on pg 2) |
| Divorce, Legal Separation or Annulment | - Add Retiree and Dependent(s) if losing coverage under Spouse's plan | Date of loss of coverage under former Spouse's plan | 35 calendar days from the Event Date | First of the month following signature date | 1 **AND** 2, 3, or 4 (on pg 2) |
| Spouse's Death | - Add Retiree and/or Dependent(s) including Tag-Alongs; if coverage is lost due to Spouse's death [16] | Date of loss of coverage under deceased Spouse's plan | 35 calendar days from the Event Date | First of the month following signature date | 1 **AND** 2, 3, or 4 (on pg 2) |
| **CHANGE IN NUMBER OF DEPENDENTS** | | | | | |
| Birth, Adoption, Placement for Adoption | - Add new child, Retiree, Spouse or other Dependent(s) including Tag-Alongs [16] | **Birth**: Date of Birth<br>**Adoption**: Date of Adoption<br>**Foreign Adoption**: Date Visa stamped<br>**Placement**: Placement Date | 35 calendar days from the Event Date | **Birth**: Date of Birth<br>**Adoption**: Date of Adoption<br>**Foreign Adoption**: Date Visa stamped<br>**Placement**: Placement Date | 1 (on pg 2) |
| Order requiring coverage for child under Retiree's plan – signed by a judge | - Add Dependent(s) to existing plan if required by a court order, placement by CHFS or if legal guardianship has been awarded [16]<br>- Enroll Retiree if the court order stipulates to add children to Retiree's plan | Date order, notice or guardianship documents are signed by a judge or authorized individual | 35 calendar days National Medical Support Notice (NMSN) **may** be processed beyond 35 days | First of the month following signature date | 1 (on pg 2) |
| **CHANGE IN EMPLOYMENT STATUS** | | | | | |
| Loss of employer-sponsored health coverage | - Add Retiree, Spouse and/or Dependent(s), including Tag-Alongs, if event causes loss of coverage under employer-sponsored health plan [16] | Date of loss of coverage under the employer-sponsored group health plan | 35 calendar days from the Event Date | First of the month following signature date | 1 **AND** 2, 3, or 4 (on pg 2) |
| **CHANGE IN COVERAGE UNDER OTHER EMPLOYER PLAN/MARKETPLACE PLAN** | | | | | |
| Other Employer plan decreases or ceases coverage | - Add Retiree, Spouse and/or Dependent(s) if they have elected or received corresponding decreased coverage under the employer plan | Date of coverage change | 35 calendar days from the Event Date | First of the month following signature date | 1 **AND** 6 (on pg 2) |
| Open Enrollment under other plan/different year | - Add Retiree, Spouse or Dependent(s) if electing to end coverage during other Open Enrollment | Last day of the other Open Enrollment period | 35 calendar days from the Event Date | Same as the Effective Date of the other Employer's plan | 1 **AND** 5 (on pg 2) |
| Open or Special Enrollment at Marketplace | - Add Retiree, Spouse or Dependent(s) provided OE is after KEHP OE | Last day of the Exchange Special or Open Enrollment | 35 calendar days from the Event Date | No earlier than the Exchange coverage effective date | 1 **AND** 7 or 8 (on pg 2) |

| Event | Allowed Changes | Event Date | Signature Deadline | Effective Date | DOCUMENTS REQUIRED |
|---|---|---|---|---|---|
| **LOSS OF HEALTH COVERAGE** | | | | | |
| Loss of eligibility for health coverage sponsored by a governmental or educational institution | - Add Retiree, Spouse or Dependent(s) if coverage group health coverage lost was sponsored by governmental or educational institution [14, 16]<br>- Prospective change only<br>- Tag-Alongs allowed | Date of loss of coverage | 35 calendar days from the Event Date | First of the month following signature date | 1 **AND** 9 or 10 (below) |
| Loss of Eligibility for individual health coverage (Marketplace) | - Add Retiree, Spouse or Dependent(s) losing individual health coverage purchased from the Exchange | Loss of eligibility date | 35 calendar days from the Event Date | First of the month following signature date | 1 **AND** 12 (below) |
| Loss of group health coverage | - Add Retiree, Spouse or Dependent(s) who has lost coverage if losing group health coverage | Date of loss of coverage | 35 calendar days from the Event Date | First of the month following signature date | 1 **AND** 2 or 3 (below) |
| **OTHER EVENTS** | | | | | |
| Gaining premium assistance subsidy from Medicaid or CHIP | - Add Retiree or Dependent(s) who have become eligible for premium assistance subsidy from Medicaid or CHIP [16] | Date premium assistance is gained | 35 calendar days from the Event Date | First of the month following signature date | 1 **AND** 9 or 11 (below) |
| Incarceration ends | - Add Retiree, Spouse or Dependent(s) who satisfy plan eligibility requirements after incarceration | Date incarceration ends | 35 calendar days from the Event Date | First of the month following signature date | 1 **AND** 15 (below) |

**REQUIRED DOCUMENTATION**

1. Dependent Eligibility Documentation (see chart on Memorandum – Verification Documentation Required)
2. Letter from Employer on letterhead or electronically that includes:
   a. Name(s) of person(s) covered
   b. Coverage termination date
   c. Reason for termination
3. Letter from insurance company that includes:
   a. Type of coverage
   b. Reason for termination
   c. Date of termination
   d. Name(s) of person(s) covered
4. Termination letter from governmental agency providing previous coverage
5. Letter from employer on employer's letterhead, identifying:
   a. Open Enrollment period and deadline
   b. Effective Date of plan
   c. Person(s) being dropped from the policy
6. Proof of change in other employer coverage.
7. Documentation from Exchange insurer or the Exchange showing:
   a. Person(s) covered
   b. Effective date of coverage
8. Confirmation printout or letter from the Exchange showing the coverage was purchased through the Exchange
9. Medicare Enrollment-Termination Form
10. Notification from Medicare
11. Letter from Medicaid or CHIP
12. Proof of loss of eligibility from Marketplace
13. The Retiree must provide the reason the Dependent is re-establishing eligibility under the guidelines of KEHP
14. Applies only to LOSS of coverage. Governmental programs include:
    a. CHIP
    b. A medical care program of an Indian Tribal government
    c. A state health risk pool
    d. A foreign government group health plan
15. Documentation from the jail/prison stating name and release date
16. QE permits change in Plan Option (LivingWell CDHP, LivingWell PPO, Standard PPO, or Standard CDHP).

**NOTES:**

- All Qualifying Events require an Enrollment/Change Application to be completed and submitted with the required documentation
- Military Insurance Coverage is considered "Another Employer Plan," however, Veteran's Administration (VA) benefits are **NOT** considered "Another Employer Plan."
- All Qualifying Event Forms should be signed within 35 days of the Qualifying Event (unless otherwise stated on the QE chart)
- If coverage terminates mid-month, you cannot sign the QE Application to begin before the termination (unless otherwise stated on the QE chart)
- The final regulation preamble indicates that dependents who can be added are those who were directly affected by the status change event plus other dependents (the so-called "tag-along" rule). However, the examples in the regulation only explicitly deal with situations where an employee elects family coverage and adds family members at no additional cost. It is not clear, but IRS staff members have informally stated that the "tag-along" rule applies even if the employee must increase an election to add additional dependents. Also, the preamble and examples in the regulation indicate that the "tag-along" rule applies to HIPAA events and situations where a spouse terminates employment; it is not clear what other events might be covered by the "tag-along" rule.

# Dependent Eligibility Chart

| Definition of Eligible Dependent(s) | Documentation |
|---|---|
| **Spouse:** A person who is legally married to an Employee or Retiree. | A legible photocopy of the marriage certificate or a legible photocopy of the top half of the front page of the Employee/Retiree's most recent federal tax return (Form 1040). |
| **Common Law Spouse:** A person with whom you have established a common law union in a state which recognizes common law marriage (Kentucky does not recognize common law marriage). | A legible photocopy of the certificate or affidavit of common law marriage from a state that does recognize common law marriage. |
| **Child Age 0 to 25:** In the case of a child who has not yet attained his/her 26th birthday, "child" means an individual who is –<br>• A son, daughter, stepson, or stepdaughter of the Employee/Retiree, or<br>• An eligible foster child of the Employee/Retiree (eligible foster child means an individual who is placed with the Employee/Retiree by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction and includes court awards of guardianship or custody), or<br>• An adopted child of the Employee/Retiree (a legally adopted individual of the Employee/Retiree, or an individual who is lawfully placed with the Employee/Retiree for legal adoption by the Employee/Retiree). | **Natural Child:** A legible photocopy of the child's birth certificate showing the name of the Employee/Retiree as a parent, or a copy of the footprint certificate from the hospital indicating baby and parent's name, or verification of the birth document from the hospital indicating the names of the baby and parent.<br><br>**Step Child:** A legible photocopy of the child's birth certificate showing the name of the Employee/Retiree's Spouse as a parent and a legible copy of the marriage certificate showing the names of the Employee/Retiree and the Spouse; or a photocopy of the top half of the front page of the Employee/Retiree's most recent federal tax return (Form 1040).<br><br>**Legal Guardian, Adoption, or Foster Child(ren):** Legible photocopies of court orders, guardianship documents, or affidavits of dependency, with the presiding judge's signature and filed status; or legible adoption or legal placement decrees with the presiding judge's signature. |
| **Disabled Dependent:** A Dependent child who is totally and permanently disabled may be covered by KEHP beyond the end of the month in which he/she turns 26, provided the disability (a) started before his/her 26th birthday and (b) is medically-certified in writing by a physician. A Dependent child will be considered totally and permanently disabled if, in the judgment of KEHP's medical Third Party Administrator (Anthem), the written certification adequately demonstrates that the Dependent child is unable to engage in any substantial gainful activity by reason of medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months. A Dependent child who is not already covered by KEHP at the time of his/her 26th birthday may not later be enrolled in KEHP on grounds of total and permanent disability unless and until he/she sustains a loss of other insurance coverage. In such a case, a request to enroll a Dependent child in KEHP on grounds of total and permanent disability must be made no later than 35 calendar days following the loss of other insurance coverage. | Anthem certifies all disabled Dependents based on medical necessity and Member's financial responsibility for the Dependent. Contact the Enrollment Information Branch at 502-564-1205 for more information. Dependents under age 26 will be enrolled by EIB as a disabled Dependent and Anthem will initiate disabled Dependent certification process. Dependent over age 26, EIB receives request from Member based on loss of other insurance coverage and requests Anthem to initiate disabled Dependent certification process. |