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: Dropping Dependents

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

If a qualifying event has occurred, you should complete the attached Retiree Health Insurance Qualifying Event Form to make the appropriate change and return it with the required documentation (see QE chart). Be mindful of the date you sign to avoid double coverage or a lapse of coverage, but no later than the deadline mentioned above. If documentation is required and not provided, your application cannot be processed.

If you have any questions, please contact our office.

479 Versailles Road • Frankfort, Kentucky 40601-3800
Phone 502-848-8500 • https://trs.ky.gov

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

2018 RETIREE HEALTH INSURANCE QUALIFYING EVENT APPLICATION

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?

SSN	Name	Relationship		Date of Birth	Sex	Tobacco
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

QUALIFYING EVENT (QE) CHART WITH DOCUMENTATION REQUIREMENTS TO DROP/TERMINATE

Rev 8/2018

Event	Allowed Changes	Event Date	Signature Deadline	Effective Date	DOCUMENTS REQUIRED
CHANGE IN LEGAL MARITAL STATUS					
Marriage	- Waive coverage or drop dependent(s) if gaining coverage under new Spouse's plan [13]	Date other group Health Insurance is gained under Spouse's plan	35 calendar days from the Event Date	End of the month of signature date	1, 2, or 3
Divorce, Legal Separation or Annulment	- Drop Spouse - Drop any Dependent(s) who lose eligibility (such as a stepchild) [13]	Date of divorce decree, annulment or legal separation as entered by the court	35 calendar days from the Event Date	End of the month of signature date	4 or 5
Spouse's Death	- Drop Spouse [9]	Date of death	35 calendar days from the Event Date	End of the month of spouse's death (regardless of whether the 35-day deadline is met)	None
CHANGE IN NUMBER OF DEPENDENTS					
Birth, Adoption, Placement for Adoption	- Terminate coverage for Retiree, Spouse, or Dependent(s) if gaining coverage through Spouse's plan	Date other group Health Insurance is gained under Spouse's plan	35 calendar days from the Event Date	End of the month of signature date	1 or 2
Dependent's Death	- Drop Dependent [13]	Date of death	35 calendar days from the Event Date	End of the month of Dependent's death	None
Order requiring coverage for a Dependent, Due to a new order releasing the Retiree – signed by a judge	- Drop Dependent	Date of the order	35 calendar days from the Event Date	End of the month of signature date	6
CHANGE IN COVERAGE UNDER OTHER EMPLOYER/MARKETPLACE PLAN					
Gaining other employer-sponsored health coverage	- Terminate coverage for Retiree, Spouse, or Dependent(s) if gaining coverage through employer-sponsored health plan	Date other group Health Insurance coverage is gained	35 calendar days from the Event Date	End of the month of signature date	1, 2, or 3
Open Enrollment under other Employer plan/different year	- Terminate coverage for Retiree, Spouse, or Dependent(s)	Last day of the employer's open enrollment period	35 calendar days from the Event Date	Same as the Effective Date of the other Employer's plan	7
Open or Special Enrollment at Marketplace	- Retiree may revoke election for self, Spouse, and Dependent(s) provided the revocation corresponds to intended enrollment of Retiree/Spouse/Dependent in coverage through the Exchange that is effective no later than the day after the last day of Employer-provided coverage	Last day of the Exchange Special or Open Enrollment	35 calendar days from the Event Date	No earlier than the Exchange coverage effective date	8 **AND** 9

Event	Allowed Changes	Event Date	Signature Deadline	Effective Date	DOCUMENTS REQUIRED
MEDICARE OR MEDICAID ENTITLEMENT					
Becomes entitled to Medicaid	- Terminate coverage for Retiree, Spouse or Dependent(s) who are gaining Medicaid	Date Retiree, Spouse, or Dependent(s) gain entitlement to Medicaid	60 calendar days from the Event Date	End of the month of signature date	10
Becomes entitled to Medicare	- Terminate coverage for Retiree, Spouse or Dependent(s) who are gaining Medicare	Date Retiree, Spouse, or Dependent(s) gain entitlement to Medicare	35 calendar days from the Event Date	End of the month of signature date	11 or 12

REQUIRED DOCUMENTATION

1. Notification from employer, on employer's letterhead or via electronically identifying:
   a. Coverage Effective Date
   b. Person(s) covered by the policy
2. A copy of the new Health Insurance ID card(s) for each covered person, with coverage Effective Date. Note: Health Insurance ID card is not sufficient unless accompanied by some form of written verification from the employer
3. An email from the employer with HR signature block or a self-service enrollment confirmation that states:
   a. Employer name
   b. Effective Date
   c. Person(s) covered
4. Divorce decree, legal separation orders, or annulment orders signed by a judge and date-stamped “filed” or “entered”
5. A court order resulting from a divorce or separation that indicates a Spouse and/or Dependent(s) should be dropped
6. Order signed by a judge
7. Notification from employer on employer’s letterhead or electronically, identifying:
   a. Open Enrollment period and deadline
   b. Effective date of plan
   c. Person(s) being added to the policy
8. Documentation from Exchange insurer or the Exchange showing:
   a. Person(s) covered
   b. Effective date of coverage
9. Printout or letter from the Exchange showing the coverage was purchased through the Exchange
10. Medicaid Eligibility/Termination (MET) Form signed by the Division of Medicaid Services – Cabinet for Health and Family Services. Contact TRS for a copy of the form.
11. Copy of the Medicare card showing Effective Date
12. Initial eligibility letter from Medicare office
13. 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)