Kentucky Employees' Health Plan
Department of Employee Insurance
KRS 800-928-4646; TRS 800-618-1687; LRP/JRP 502-564-5310

KENTUCKY PERSONNEL CABINET | Department of Employee Insurance

2019 RETIREE HEALTH INSURANCE ENROLLMENT/CHANGE 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

Reason(s) for Application:
☐ New Retiree
☐ Returning Retiree
☐ Return to Work Retiree
☐ Qualifying Event
☐ Change or Update
☐ Grievance

Qualifying Event:
☐ Marriage
☐ Birth/Adoption/Placement
☐ Court Order for Child
☐ Divorce
☐ Death – Date:_____
☐ Loss of Individual Health
☐ Loss of Group Health

☐ Begin Medicare/Medicaid
☐ End Medicare/Medicaid
☐ Loss of KCHIP
☐ Spouse/Dependent Starting Employment
☐ Spouse/Dependent Terminating Employment
☐ Special Enrollment
☐ Other:

Section 2: Demographic Information - Changes or Current (Circle one)

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

Applicant's SSN	Applicant's Name (Last, First, MI) If plan holder is not the Retiree	Applicant's Date of Birth

Street Address	Primary Phone #	Secondary Phone #

City, State Zip	County Code	Home Email Address

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

***Required information for processing. Are you Medicare eligible due to Social Security disability? ☐Yes ☐No

Section 3: Spouse Information – Skip to Section 5 if electing single coverage - Changes or Current (Circle one)

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

***Required information for processing. 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 - Changes or Current (Circle one)

*** Required information for processing. 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	☐Add ☐ Drop ☐Remain
Child #2 SSN	Name (Last, First, MI)	☐ Natural ☐ Foster ☐ Adopted ☐ Step ☐ Court Ordered ☐ Disabled	Date of Birth	☐Male ☐Female	☐Add ☐ Drop ☐Remain
Child #3 SSN	Name (Last, First, MI)	☐ Natural ☐ Foster ☐ Adopted ☐ Step ☐ Court Ordered ☐ Disabled	Date of Birth	☐Male ☐Female	☐Add ☐ Drop ☐Remain
Child #4 SSN	Name (Last, First, MI)	☐ Natural ☐ Foster ☐ Adopted ☐ Step ☐ Court Ordered ☐ Disabled	Date of Birth	☐Male ☐Female	☐Add ☐ Drop ☐Remain

Retiree's SSN:		**Applicant's SSN:**				
Child #5 SSN	Name (Last, First, MI)	☐ Natural ☐ Adopted ☐ Court Ordered	☐ Foster ☐ Step ☐ Disabled	Date of Birth	☐Male ☐Female	☐Add ☐ Drop ☐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. 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.

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

Section 8: Signatures – Please submit this application to your Company Insurance Coordinator – ADDRESS BELOW

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-If plan holder is not the retiree	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

Kentucky Retirement System 1260 Louisville Road Frankfort, KY 40601	Teachers' Retirement System 479 Versailles Road Frankfort, KY 40601	LRP/JRP 305 Ann Street Frankfort, KY 40601