

PLAN YEAR 2024 RETIREE HEALTH INSURANCE ENROLLMENT/CHANGE FORM

Section 1: To Be Completed by Insurance Coordinator										
KHRIS Personnel Number		Hazardous Duty <input type="checkbox"/>	Date of Retirement	Qualifying Event Date		Coverage Effective Date				
<input type="checkbox"/> KPPA 80000 10006416		<input type="checkbox"/> TRS 85000 10006418		<input type="checkbox"/> KTCRS 81000 10006417		<input type="checkbox"/> JRP 86000 10006419		<input type="checkbox"/> LRP 87000 10006420	<input type="checkbox"/> KPPA RTW 80100 10006464	
KPPA Only:		<input type="checkbox"/> KPPA - KERS		<input type="checkbox"/> CERS – Oth. Ag		<input type="checkbox"/> KPPA – SPRS				
Reason(s) for Application:			Qualifying Event:			Termination:				
<input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Retiree <input type="checkbox"/> Returning Retiree <input type="checkbox"/> Applicant becomes the PH <input type="checkbox"/> Qualifying Event <input type="checkbox"/> Exception <input type="checkbox"/> Demographic Change <input type="checkbox"/> Termination			<input type="checkbox"/> Marriage <input type="checkbox"/> Birth/Adoption/Placement <input type="checkbox"/> Court Order for Child <input type="checkbox"/> Divorce <input type="checkbox"/> Death – Date: <input type="checkbox"/> Loss of Individual Health <input type="checkbox"/> Loss of Group Health <input type="checkbox"/> Spouse turned 65			<input type="checkbox"/> Begin Medicare/Medicaid <input type="checkbox"/> End Medicare/Medicaid <input type="checkbox"/> Loss of KCHIP <input type="checkbox"/> Spouse/Dependent Starting Employment <input type="checkbox"/> Spouse/Dependent Terminating Employment <input type="checkbox"/> Special Enrollment <input type="checkbox"/> Other:			Termination: Coverage End date	
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			
Mailing Address				Primary Phone #		Secondary Phone #				
City, State Zip			Home County			Home Email Address				
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female			Married: <input type="checkbox"/> Yes <input type="checkbox"/> No							
***Required information for processing. Are you Medicare eligible due to Social Security disability? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> Female		
***Required information for processing. Is Spouse Medicare eligible due to Social Security disability? <input type="checkbox"/> Yes <input type="checkbox"/> No										
<input type="checkbox"/> I wish to utilize the Cross-reference payment option (two KEHP members, married with children – no LRP or JRP).										
KPPA Only:		<input type="checkbox"/> KPPA - KERS		<input type="checkbox"/> CERS – Oth. Ag		<input type="checkbox"/> KPPA - 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, who?			
Child #1 SSN		Name (Last, First, MI)		<input type="checkbox"/> Natural <input type="checkbox"/> Foster <input type="checkbox"/> Adopted <input type="checkbox"/> Step <input type="checkbox"/> Court Ordered <input type="checkbox"/> Disabled		Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	
Child #2 SSN		Name (Last, First, MI)		<input type="checkbox"/> Natural <input type="checkbox"/> Foster <input type="checkbox"/> Adopted <input type="checkbox"/> Step <input type="checkbox"/> Court Ordered <input type="checkbox"/> Disabled		Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	
Child #3 SSN		Name (Last, First, MI)		<input type="checkbox"/> Natural <input type="checkbox"/> Foster <input type="checkbox"/> Adopted <input type="checkbox"/> Step <input type="checkbox"/> Court Ordered <input type="checkbox"/> Disabled		Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	
Child #4 SSN		Name (Last, First, MI)		<input type="checkbox"/> Natural <input type="checkbox"/> Foster <input type="checkbox"/> Adopted <input type="checkbox"/> Step <input type="checkbox"/> Court Ordered <input type="checkbox"/> Disabled		Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	
Child #5 SSN		Name (Last, First, MI)		<input type="checkbox"/> Natural <input type="checkbox"/> Foster <input type="checkbox"/> Adopted <input type="checkbox"/> Step <input type="checkbox"/> Court Ordered <input type="checkbox"/> Disabled		Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	

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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has your spouse, if covered under this plan, used tobacco regularly within the past 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have any children covered under this plan age 18 or older used tobacco regularly within the past 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who?
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Section 6: Coverage Level – Verification documents may be required; check with your Insurance Coordinator or HR office.
Note: If adding newly covered dependents you may be required to provide verification documents to Alight, the dependent audit vendor. Alight will contact you if verification documents are required.

<input type="checkbox"/> Single (self only)	<input type="checkbox"/> Parent Plus (self and child(ren))	<input type="checkbox"/> Couple (self and spouse)	<input type="checkbox"/> Family (self, spouse, and child(ren))
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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
 Default LivingWell Basic CDHP (no HRA funds) – INSURANCE COORDINATOR USE ONLY
 Waive Coverage, No HRA – without \$ Reason for Waiving:

Section 8: Signatures – Please submit this application to your retirement agency 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 Public Pensions Authority
1260 Louisville Road
Frankfort, KY 40601

Teachers' Retirement System
479 Versailles Road
Frankfort, KY 40601

Judicial Retirement Plan
Legislators Retirement Plan
305 Ann Street, Suite 302
Frankfort, KY 40601

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, LivingWell Basic CDHP, or LivingWell Limited High Deductible Plan).

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 Applications should be signed within 35 days of the Qualifying Event (unless otherwise stated on the QE chart)