TEAM KENTUCKY PERSONNEL CABINET | Department of Employee Insurance

# EXCEPTION FORM

Send through the DEI Form Upload

PLANHOLDER'S PERSONAL INFORMATION

| Name and mailing address | Effective Date of Requested Change: |
|---|---|
| | Agency/Employer Name |
| | IC/HR Name |
| | Agency Number |
| | Telephone No. |
| | KHRIS Per Nr |
| | SSN |

**EXPLAIN REASON FOR EXCEPTION REQUEST BY ANSWERING THE QUESTIONS BELOW** *(Must include the appropriate enrollment application or the exception request will not be reviewed. Be as specific as possible; the request may be denied.)*

WHAT IS THE EXACT PLAN CHANGE YOU ARE REQUESTING?

WHAT EXTENUATING CIRCUMSTANCE PREVENTED YOU FROM MEETING THE INITIAL DEADLINE?

EXPLAIN WHO IS RESPONSIBLE FOR THE EXCEPTION REQUEST *(This explanation must describe who caused the error and the specific measures that will be taken to avoid a similar issue in the future.)*

*By signing below, I swear, or affirm, that the information provided above is accurate and complete to the best of my recollection and belief. I also hereby promise to respond to any KEHP inquiry or clarification regarding the information above, within a reasonable period of time.*

Member Printed Name _____ Member Signature (*or e-sign by typing name*) _____ Date _____

IC/HRG Printed Name _____ IC/HRG Signature (*or e-sign by typing name*) _____ Date _____

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TO BE COMPLETED BY THE DEPARTMENT OF EMPLOYEE INSURANCE

Date Received: Date of Decision: Approved: ☐ Denied: ☐ Effective Date of Change:

*(Approved exceptions are effective the 1st day of the month following the signature date of the exception request)*

Reason if denied:

- ☐ Required document(s) not attached
- ☐ Filed past 30-days of the event date
- ☐ No extenuating circumstance
- ☐ Other
- ☐ Request conflicts with state and/or federal laws
- ☐ No exception to the LivingWell Promise