

PLAN YEAR 2025 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"/> KCTCRS 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: | |
| 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 # |
| City, State Zip | | Secondary Phone # |
| 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) | <input type="checkbox"/> Male <input type="checkbox"/> Female | <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain |
| ***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 members, married with children). Not available to new retirees (new to KEHP) after 1/1/2025 | | | | |
| 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)

| | | | | | |
|---|------------------------|---|---|---------------|---|
| 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"/> Adopted <input type="checkbox"/> Court Ordered | <input type="checkbox"/> Foster <input type="checkbox"/> Step <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"/> Adopted <input type="checkbox"/> Court Ordered | <input type="checkbox"/> Foster <input type="checkbox"/> Step <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"/> Adopted <input type="checkbox"/> Court Ordered | <input type="checkbox"/> Foster <input type="checkbox"/> Step <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"/> Adopted <input type="checkbox"/> Court Ordered | <input type="checkbox"/> Foster <input type="checkbox"/> Step <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"/> Adopted <input type="checkbox"/> Court Ordered | <input type="checkbox"/> Foster <input type="checkbox"/> Step <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? |
|--|--|--|

Section 6: Coverage Level – Verification documents may be required; check with your Insurance Coordinator or HR office.
Note: If adding newly covered dependents you will be required to provide dependent verification documents.

| | | | |
|---|--|---|--|
| <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)) |
|---|--|---|--|

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 kehp.ky.gov in the Benefits Selection Guide.

LivingWell CDHP
 LivingWell PPO
 LivingWell Basic CDHP
 LivingWell High Deductible Health Plan
 Default Waiver w/o HRA (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 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 Adoption: Date of Adoption Foreign Adoption: Date Visa stamped Placement: Placement Date | 35 calendar days from the Event Date | Birth: Date of Birth Adoption: Date of Adoption Foreign Adoption: Date Visa stamped 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 - 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} - Prospective change only - 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 and Reason for termination
3. Letter from insurance company that includes:
 - a. Type of coverage
 - b. Date of termination and Reason for termination
 - c. 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, LivingWell Basic CDHP, or LivingWell 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)
- 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 |
|---|---|
| <p>Spouse: A person who is legally married to an Employee or Retiree.</p> | <p>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).</p> |
| <p>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).</p> | <p>A legible photocopy of the certificate or affidavit of common law marriage from a state that does recognize common law marriage.</p> |
| <p>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 –</p> <ul style="list-style-type: none"> • A son, daughter, stepson, or stepdaughter of the Employee/Retiree, or • 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 • 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). | <p>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.</p> <p>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).</p> <p>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.</p> |
| <p>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.</p> | <p>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.</p> |