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

TEAM KENTUCKY PERSONNEL CABINET | Kentucky Employees' Health Plan

PLAN YEAR 2025 RETIREE HEALTH INSURANCE ENROLLMENT/CHANGE FORM

Section 1: To Be Completed by Insurance Coordinator

KHRIS Personnel Number	Hazardous Duty ☐	Date of Retirement	Qualifying Event Date	Coverage Effective Date

☐ KPPA 80000 10006416	☐ TRS 85000 10006418	☐ KCTCRS 81000 10006417	☐ JRP 86000 10006419	☐ LRP 87000 10006420	☐ KPPA RTW 80100 10006464

KPPA Only:	☐ KPPA - KERS	☐ CERS – Oth. Ag	☐ KPPA – SPRS

Reason(s) for Application:
☐ Open Enrollment
☐ New Retiree
☐ Returning Retiree
☐ Applicant becomes the PH
☐ Qualifying Event
☐ Exception
☐ Demographic Change
☐ Termination

Qualifying Event:
☐ Marriage
☐ Birth/Adoption/Placement
☐ Court Order for Child
☐ Divorce
☐ Death – Date:
☐ Loss of Individual Health
☐ Loss of Group Health
☐ Spouse turned 65
☐ Begin Medicare/Medicaid
☐ End Medicare/Medicaid
☐ Loss of KCHIP
☐ Spouse/Dependent Starting Employment
☐ Spouse/Dependent Terminating Employment
☐ Special Enrollment
☐ 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: ☐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)	☐Male ☐Female	☐Add ☐ Drop ☐Remain

***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 members, married with children). ***Not available to new retirees (new to KEHP) after 1/1/2025***

KPPA Only:	☐ KPPA - KERS	☐ CERS – Oth. Ag	☐ 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? ☐ 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
Child #5 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:**

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 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.

☐ 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 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 – <u>ADDRESS BELOW</u>
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)