TEAM KENTUCKY PERSONNEL CABINET | Department of Employee Insurance

EXCEPTION FORM

Send through the DEI Form Upload
MUST COMPLETE ALL SECTIONS

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