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 2026 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

Race/Ethnicity Data: The Commonwealth of Kentucky does not discriminate on the basis of race, color, religion, sex, national origin, sexual orientation, gender identity or expression, ancestry, age, pregnancy or related medical condition, marital or familial status, disability, veteran status, political affiliation, or genetic information, in accordance with state and federal laws. **Completion of the questions below is OPTIONAL and will NOT affect the terms or conditions of your medical coverage or your eligibility for medical coverage.** The federal government strongly encourages employers and health plans to collect social data about individuals to better identify environmental and personal conditions that affect a wide range of health and quality-of-life outcomes. **This data will be kept private and used only to help the Commonwealth of Kentucky better understand how to provide healthcare services to you.** *Please select the one category with which you identify:*

☐Hispanic or Latino ☐ White (Non-Hispanic or Latino) ☐Black or African American (Non-Hispanic or Latino) ☐Asian (Non-Hispanic or Latino) ☐Native Hawaiian or Other Pacific Islander (Non-Hispanic or Latino) ☐American Indian or Alaska Native (Non-Hispanic or Latino) ☐Two or More Races ☐Prefer Not to Answer

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 ☐ Adopted ☐ Court Ordered ☐ Foster ☐ Step ☐ Disabled	Date of Birth	☐Male ☐Female	☐Add ☐ Drop ☐Remain

Child #2 SSN	Name (Last, First, MI)	☐ Natural ☐ Adopted ☐ Court Ordered ☐ Foster ☐ Step ☐ Disabled	Date of Birth	☐Male ☐Female	☐Add ☐ Drop ☐Remain

Retiree's SSN: **Applicant's SSN:**

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

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 –

Note: If adding newly covered dependents you will be contacted later to provide dependent verification documents to our dependent eligibility audit vendor.

☐ 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 (no HRA funds) 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