



2012 KEHP
RETIRES ENROLLMENT/CHANGE APPLICATION

Section 1: Insurance Coordinator Section

KRS CERS/Area Dev CERS/City Govt CERS/County Govt
 80000 CERS/Loc School CERS/Loc School CERS/Other Agency
 10006416 CERS/Sheriffs KRS/KERS KRS/KRS KRS/SPRS

Planholder's Personnel Number: _____

Coverage Effective Date: ____/____/2012 KTRS JRP LRP Hazardous
 85000 86000 87000 Duty
 Three-Digit County Code: _____ 10006418 10006419 10006420

Reason for Application

<input type="checkbox"/>	New Retiree
<input type="checkbox"/>	Open Enrollment
<input type="checkbox"/>	QE
<input type="checkbox"/>	Other Reason

If QE – Select Reason Date of Event: __/__/____

Deletion of Dependent	Addition of Dependent		
<input type="checkbox"/>	Divorce	<input type="checkbox"/>	Marriage
<input type="checkbox"/>	Death	<input type="checkbox"/>	Birth/Adoption of Child
<input type="checkbox"/>	Loss of Eligibility	<input type="checkbox"/>	Guardianship/Court Order
<input type="checkbox"/>	Gaining Other Coverage	<input type="checkbox"/>	Loss of Other Coverage
<input type="checkbox"/>	Gaining Medicare/Medicaid	<input type="checkbox"/>	Loss of KCHIP/Medicaid
<input type="checkbox"/>	Other Reason	<input type="checkbox"/>	Re-establishing Eligibility
		<input type="checkbox"/>	Special Enrollment

Section 2: Demographic Information

Retiree SSN (required) Retiree Name (Last, First, Middle Initial) Retiree Date of Birth

Applicant SSN (if retiree is not applying) Applicant Name (Last, First, Middle Initial) Applicant Date of Birth

Home Address City, State, Zip Home County (Code/Name)

Home Phone Number Cell Phone Number E-mail Address

Gender Male Female Marital Status Married Single Have You Smoked in the Last Two Months? Yes No

Section 3: Dependent Information

SOCIAL SECURITY NUMBER	NAME (FIRST, MI, LAST)	BIRTH DATE MONTH/DAY/YEAR	GENDER	
Spouse		__/__/__	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Child 1		__/__/__	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Natural <input type="checkbox"/> Foster <input type="checkbox"/> Adopted <input type="checkbox"/> Step <input type="checkbox"/> Court Ordered <input type="checkbox"/> Disabled
Child 2		__/__/__	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Natural <input type="checkbox"/> Foster <input type="checkbox"/> Adopted <input type="checkbox"/> Step <input type="checkbox"/> Court Ordered <input type="checkbox"/> Disabled
Child 3		__/__/__	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Natural <input type="checkbox"/> Foster <input type="checkbox"/> Adopted <input type="checkbox"/> Step <input type="checkbox"/> Court Ordered <input type="checkbox"/> Disabled

Section 4: Cross Reference Information

Cross Reference Payment Option (JRP, LRP not eligible) Yes (Retiree, and/or Employee and Child(ren))

Spouse's Company Number: _____ Spouse's Organizational Unit Number: _____

Is Your Spouse Hazardous Duty: Yes No Spouse's Date of Hire/Retirement: __/__/____

Has your spouse smoked in the last 2 months? Yes No

Turn Form Over for Plan Election and Signatures

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Retiree's SSN

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Applicant's SSN

Section 5: Plan Election

Benefit Options

<input type="checkbox"/> Commonwealth Standard PPO
<input type="checkbox"/> Commonwealth Capitol Choice
<input type="checkbox"/> Commonwealth Optimum PPO
<input type="checkbox"/> Waiver (No Health Insurance)

Coverage Level

<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))

Authorization and Certification

I understand and agree that:

- I have made the plan selection for plan year 2012. I have read and understand the 2012 KEHP Benefits Selection Guide. I understand that plan rules and limitations are contained in the KEHP Summary Plan Descriptions.
- My signature on this application creates a legal and binding contract between the Department of Employee Insurance (DEI), Kentucky Employees' Health Plan (KEHP), third-party administrators including Humana and Express Scripts, and me.
- If my spouse and I elect the cross-reference payment option, we are planholders with Family coverage and that upon a loss of eligibility by either spouse; the remaining planholder will default to Parent Plus coverage. The cross-reference payment option ceases upon loss of eligibility or employment by either spouse/planholder. (This option is not available to LRS/JRS retirees.)
- I certify that each enrolled dependent meets KEHP eligibility requirements of a dependent as set forth in the Summary Plan Descriptions and in the KEHP Benefits Selection Guide. I understand that DEI requires supporting documentation to verify the eligibility of any dependent enrolled or requesting to be enrolled in the Plan. And, in addition, an affidavit **2012 Certification of Dependent Eligibility** must be submitted for dependent children between the ages of 19-26.
- All KEHP benefits for my eligible dependents and me will be provided in accordance with the Summary Plan Descriptions. I will abide by all terms and conditions governing membership and receipt of services from the plan in which I have enrolled as set forth in the Summary Plan Descriptions.
- The elections indicated on this application may not be changed or cancelled during the plan year without a permitted Qualifying Event.
- I authorize my Retirement System to deduct from my earnings the amount required to cover my share of the coverage I have selected, including any arrears I may owe.
- I authorize the release of medical claims data to my Retirement System for use in data analysis and referral to available health related services upon their review.
- I authorize my Retirement System to release the information in this application to the Social Security Administration. The information in this application may be used by the Social Security Administration to determine Medicare eligibility. I further acknowledge that Medicare eligibility may affect my participation in KEHP.
- This plan has a tobacco incentive for members who do not use tobacco and that this plan offers reasonable alternatives i.e. tobacco cessation.
- I have rights under HIPAA and that DEI will comply with the HIPAA rules and that disclosure of protected information will be done under the rules of such Federal Law. I further authorize DEI to use such information and to disclose such information to business associates, third party administrators, vendors, consultants, governmental agencies with jurisdiction and other necessary parties when necessary for my care or treatment, payment for services, the operation of my health plan or to conduct related activities.
- Plan terms permit rescission of coverage with respect to an individual if the individual engages in an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of a material fact.
- Any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance containing any forged signature or incorrect signature date thereto commits a fraudulent insurance act, which is a crime. I understand that I can be held responsible for any fraudulent act that is the result of a forged signature or incorrect signature date that I could have prevented while acting within my duties related to the KEHP and it may be used to reduce or deny a claim or to terminate my coverage.
- I have fully read the materials provided to me. My signature below certifies that all information, signatures and signature dates affixed to this contract are correct to the best of my knowledge.

Application must be signed by retirement coordinator. Please mail application to:

KY Retirement System (KRS) Perimeter Park West 1260 Louisville Road Frankfort, KY 40601	KY Teachers' Retirement (KTRS) 479 Versailles Road Frankfort, KY 40601	KY Judicial Form Retirement System (JRP/LRP) 305 Ann Street, Rm 302 Whitaker Bank Bldg. Frankfort, KY 40601
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Retiree Signature

Date

Applicant Signature (if other than retiree)

Date

Spouse Signature – *REQUIRED* if electing the cross-reference payment option

Date

Retirement Insurance Coordinator Signature

Date

Spouse's Insurance Coordinator Signature – *REQUIRED* if electing the cross-reference payment option

Date