



2012 KEHP
ACTIVE EMPLOYEE HEALTH INSURANCE ENROLLMENT APPLICATION

Section 1: To Be Completed by Insurance Coordinator/HR Generalist					
Employee's SSN	/ /	Employee Personnel Number		Home County Code	
Company Name			Company Number		
Date of Hire	/ /	Coverage Effective Date	/ /	Org. Unit Number	
Reason for Application	<input type="checkbox"/> New Hire <input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Group				
Section 2: Demographic Information					
Name (Last, First, MI)			Date of Birth / /		
Street Address		Home Phone Number		Cell Phone Number	
City, State, ZIP		Home Email Address		Work Email Address	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Married	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> I am a Dual Employee	Have you smoked in the last 2 months?
I am covered under:	<input type="checkbox"/> KY Retirement Plan	<input type="checkbox"/> Hazardous Duty Plan	<input type="checkbox"/> My spouse's Hazardous Duty Plan	<input type="checkbox"/> Medicare Supplement	<input type="checkbox"/> Yes <input type="checkbox"/> No
Section 3: Dependent Information					
Social Security Number	Name (Last, First, Middle Initial)		Birth Date MONTH/DAY/YEAR	Gender	Cross Reference Payment Option (LRP, JRP not eligible)
Spouse's			/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes (Employee, Spouse & child(ren))
Spouse's Organizational Unit #:	<input type="checkbox"/> Dual Employee	<input type="checkbox"/> Hazardous Duty	Date of hire/retirement / /	Has Spouse smoked in the last 2 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Spouse's Company #:					
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: Plan Election					
Benefit Option			Coverage Level		
<input type="checkbox"/>	Commonwealth Standard PPO		<input type="checkbox"/>	Single (self only)	
<input type="checkbox"/>	Commonwealth Maximum Choice		<input type="checkbox"/>	Parent Plus (self and child(ren))	
<input type="checkbox"/>	Commonwealth Capitol Choice		<input type="checkbox"/>	Couple (self and spouse)	
<input type="checkbox"/>	Commonwealth Optimum PPO		<input type="checkbox"/>	Family (self, spouse and child(ren))	
Section 5: Waiving Health Insurance (no health insurance)					
If you waive your health insurance and you are eligible, you will receive \$175 per month for a total of \$2100 annually into a Health Reimbursement Account (HRA). Select either the Waiver HRA, or Waiver Dental/Vision ONLY HRA.					
<input type="checkbox"/>	Waiver HRA				
<input type="checkbox"/>	Waiver Dental/Vision ONLY HRA				
<input type="checkbox"/>	No HRA – not eligible				

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Employee's SSN

Employee's Name

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.
- 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 employer 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 payment of my employee contributions to be made on a pre-tax basis unless I sign a Post-Tax Form.
- If I elect to waive KEHP health insurance coverage, with or without a stand-alone Waiver Health Reimbursement Account (HRA), I am doing so voluntarily. I understand there are two options under the HRA: Waiver HRA and the Waiver Dental/Vision ONLY HRA.
- I understand that the four KEHP medical coverage options and the Waiver HRA must pay primary to Medicare and the Waiver Dental/Vision ONLY HRA will be secondary to Medicare.
- Regarding my HRA, my dependents and I, are eligible to seek reimbursement under Sections 105 (b) and 213(d). I understand that any unused amount remaining in my HRA at the end of the Plan Year may be carried forward to the next plan year. Pursuant to federal law, the cost of over-the-counter medicines (other than doctor prescribed and insulin) may not be reimbursed through an HRA.
- I understand that a KEHP HRA can only reimburse expenses that are incurred during this plan year. I have a 90-day run-out period (until March 31) for reimbursement of eligible HRA expenses incurred during my period of coverage.
- My HumanaAccessSM Visa[®]Card will be suspended if the required HRA claim verification is not sent in to Humana within sixty (60) days after the card swipe. I agree to follow all rules and guidelines established by the plan concerning the HumanaAccessSM Visa[®]Card. This Plan reserves the right to deny access to the card, require repayment, deduct/withhold from my paycheck and offset my HRA if I fail to properly substantiate.
- 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 health 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.
- 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.

PLEASE SUBMIT THIS APPLICATION TO YOUR COMPANY INSURANCE COORDINATOR OR HRG

Employee Signature

Date

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

Date

Insurance Coordinator/HRG Signature

Date

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

Date