



KENTUCKY EMPLOYEES HEALTH PLAN

ENROLLMENT APPLICATION FOR THE KENTUCKY TEACHERS' RETIREMENT SYSTEM (KTRS) PY 2009

INSURANCE COORDINATOR SECTION

/ /

Coverage Effective Date

Company Number

Mail application to:

479 Versailles Road
Frankfort, KY 40601

Reason for Application:

< New Retiree
 < Open Enrollment
 < QE*
 < Previously Waived*
 < Other*

* If you previously waived, or marked "Other" or "QE" above, enter the Qualifying Event date _____ Date _____ Qualifying Event Description _____
AND a description of the Qualifying Event:

Additional Information: < Retiree returns to work

SECTION I: DEMOGRAPHIC INFORMATION

Is retiree applying for this coverage?
 < Yes
 < No
 If "No", what is your relationship to the retiree?

- -

RETIREE SSN (Required)

RETIREE Name (First, MI, Last)

- -

APPLICANT SSN (If retiree is not applying)

APPLICANT Name (First, MI, Last)

RETIREE AND/OR APPLICANT Specific Information

Mailing Address _____

/ /

Date of Birth (MM/DD/YYYY)

City, State, Zip Code _____

County of Residence _____

Country / Mail Code, if not USA _____

Planholder's HOME Phone Number _____

Planholder's Cell Phone Number _____

Planholder's Email Address _____

Smoking Status (Required)

Have you smoked in the last 2 months?
 < Yes
 < No

Gender

< Male
 < Female

Marital Status

< Married
 < Single

SECTION II: PLAN ELECTION- if waiving (i.e. decline) health insurance coverage, go to Section V.

1. Option (Check only one)

- < Commonwealth Standard PPO
- < Commonwealth Capitol Choice
- < Commonwealth Optimum PPO

2. Level of Coverage

- < Single
- < Parent Plus
- < Couple
- < Family

3. Cross-Reference Payment Option

(Available for Family Coverage Only)

- < Yes

If Yes, you must complete Sections III, IV & VII
If cross-referenced with an active employee, the active employee will be the planholder.

SECTION III: SPOUSE AND/OR DEPENDENT INFORMATION → If you elected Single coverage, skip to Section VII

Social Security Number	Name (First, MI, Last)	Gender (Circle one)	Date of Birth (MM/DD/YYYY)	Relationship Code
		M F		
		M F		
		M F		
		M F		

Relationship Codes: SP Spouse; CH Child; DD Disabled Dependent Child; CO Court Ordered Dependent Child

PY 2009

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Retiree's SSN

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Retiree and/or Applicant's SSN (if other than retiree)

SECTION IV: CROSS-REFERENCE INFORMATION → Complete ONLY if you checked Yes in Section II, box 3

Your Spouse's Company Number: <i>(Required)</i> _____	Dual Employee Indicator, If applicable <input type="checkbox"/> <Yes	Has your spouse smoked in the last 2 months? <i>(Required)</i> <input type="checkbox"/> <Yes <input type="checkbox"/> <No	Is your spouse a Hazardous Duty Retiree? <input type="checkbox"/> <Yes <input type="checkbox"/> <No	Your spouses Hire Date or Retirement Date: _____
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SECTION V: WAIVER

Do you wish to waive (i.e. decline) your health Insurance Coverage? < Yes
 Reason for waiving _____

SECTION VI: FLEXIBLE SPENDING ACCOUNTS (FSA)

Not Applicable → Retirees are not eligible to participate in a Flexible Spending Account.
 If a retiree elects the cross-reference payment option with an active spouse and the active spouse is eligible and wishes to enroll in the state's Flexible Spending Account Program, the active spouse and the retiree should make their health coverage elections by completing the active employee's Health Insurance Application.

SECTION VII: AUTHORIZATION AND CERTIFICATION

- * I understand that my signature on this application creates a legal and binding contract between myself, the Department of Employee Insurance and the TPA.
- * I understand that if my spouse and I elect the cross-reference payment option, we are dual plan holders and our level of coverage (Family) will automatically drop to a parent plus coverage level upon termination of employment by either spouse/planholder. The cross-reference payment option ceases upon termination of employment by either spouse/planholder.
- * I understand that this plan has a tobacco surcharge for members that use tobacco and that this plan offers tobacco cessation programs.
- * I agree to abide by the terms and conditions governing membership and receipt of services from the plan in which I have enrolled.
- * I understand that the elections indicated on this application may not be changed or canceled during the plan year, with the exception of certain Qualifying Events.
- * I authorize the Retirement System to deduct from my retirement benefits the amount required to cover my share of the coverage I have selected including any arrears I may owe.
- * I authorize the Retirement System to release the information in this application to federal and state agencies for proper administration of medical benefits. Such release of information will be made only to the extent permissible under applicable state and federal statutes. I further acknowledge that Medicare eligibility may affect my participation in the Kentucky Employees Health Plan.
- * I understand that the misrepresentation of any information on this application with the intent to defraud is a fraudulent insurance act, which is a crime, and any material misrepresentation or omission 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 the statements on this form are true and complete to the best of my knowledge.
- * I acknowledge and understand that DEI will comply with the HIPAA Rules and that disclosure of 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 third party administrators, vendors, consultants, governmental authorities 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.

I understand that 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. My signature below certifies that all signatures and signature dates affixed to this contract are correct to the best of my knowledge.

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