



# KENTUCKY EMPLOYEES HEALTH PLAN

## ENROLLMENT APPLICATION FOR THE KENTUCKY RETIREMENT SYSTEMS (KRS) PY 2009

**Mail application to:**

Perimeter Park West  
1260 Louisville Road  
Frankfort, KY 40601

**INSURANCE COORDINATOR SECTION**

<input type="text"/> / <input type="text"/> / <input type="text"/> Coverage Effective Date
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Company Number      Sp Gen      HD

**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 return 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)

**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 WORK 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.

<p><b>1. Option</b> (Check only one)</p> <p> <input type="checkbox"/> &lt; Commonwealth Standard PPO  <input type="checkbox"/> &lt; Commonwealth Capitol Choice  <input type="checkbox"/> &lt; Commonwealth Optimum PPO                 </p>	<p><b>2. Level of Coverage</b></p> <p> <input type="checkbox"/> &lt; Single  <input type="checkbox"/> &lt; Parent Plus  <input type="checkbox"/> &lt; Couple  <input type="checkbox"/> &lt; Family                 </p>	<p><b>3. Cross-Reference Payment Option</b>                      (Available for Family Coverage Only)</p> <p style="text-align: center;"><input type="checkbox"/> &lt; Yes</p> <p><b>If Yes, you must complete Sections III and IV</b>                      If cross-referenced with an active employee, the active employee will be the plan holder.</p>
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**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, CO = Court-Ordered Dependent

PY 2009

Retiree's SSN

Applicant's SSN (from Page 1, Section I)

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

Table with 5 columns: Your Spouse's Company Number, Dual Employee Indicator, Has your spouse smoked in the last 2 months?, Is your spouse a Hazardous Duty Retiree?, Your spouse's Hire Date or Retirement Date.

SECTION V: WAIVER

Do you wish to waive (i.e. decline) your Health Insurance Coverage? By checking "Yes," I understand that I am declining health insurance coverage through the KEHP for the Plan

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...

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.
\* I understand that each dependent I am enrolling meets the eligibility requirements of a dependent as set forth in the plan document and in the KEHP handbook.
\* I authorize the release of medical claims data to the Kentucky Retirement System for use in data analysis and referral to available health related services upon their review.
\* 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 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 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 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 understand that this plan has a tobacco incentive for members that do not use tobacco and that this plan offers tobacco cessation programs.
\* 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