

COMMONWEALTH OF KENTUCKY
PERSONNEL CABINET
DEPARTMENT FOR EMPLOYEE INSURANCE
2009 KEHP UPDATE FORM



Do NOT use this form to add or drop dependents. Insurance Coordinator complete form.
This form is to be used to update information on health insurance, FSAs and HRAs.

SOCIAL SECURITY NUMBER NAME	COMPANY NUMBER COMPANY NAME
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TERMINATION: DATE EMPLOYMENT ENDS _____ DATE INSURANCE TERMINATES _____

Reason: Resigned Retired LWOP* Death Military Other _____

REINSTATE: DATE RETURNED TO WORK _____ DATE INSURANCE EFFECTIVE _____

Reason: Rehired FMLA LWOP* Military Other _____

***Additional Information concerning LWOP Required:**

18A Employee:

NON 18A Employee:

TRANSFER ■ *To be completed by the NEW company*
 ■ *No changes to current coverage are allowed on this form*

PRIOR COMPANY # _____	NEW COMPANY # _____
LAST DATE WORKED AT PRIOR COMPANY _____	DATE HIRED AT NEW COMPANY _____
COVERAGE END DATE FROM PRIOR COMPANY # _____	COVERAGE BEGIN DATE AT NEW COMPANY # _____

<input type="checkbox"/> NAME	NEW _____	PREVIOUS _____
<input type="checkbox"/> NEW ADDRESS (where mail received)	_____	
CITY:	STATE:	ZIP CODE:
EMAIL:	_____	
<input type="checkbox"/> SSN	CORRECT _____	INCORRECT _____
<input type="checkbox"/> DATE OF BIRTH	_____	<input type="checkbox"/> OTHER _____

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.

EMPLOYEE SIGNATURE _____	COORDINATOR SIGNATURE _____
DATE _____	DATE _____

Insurance Coordinator: Mail this form to DEI, 501 High St., 2nd Floor, Frankfort, KY 40601