



2017 AFFORDABLE CARE ACT (ACA) HEALTH INSURANCE ENROLLMENT APPLICATION

Section 1: To Be Completed by IC/HRG			
KHRIS Personnel Number	Organizational Unit #	Company Name	Company #
Reason for Application <input type="checkbox"/> New ACA		Coverage Effective Date	Cost Center #
			Home County Code
Section 2: Demographic Information			
Employee's SSN	Employee Name (Last, First, MI)		Date of Birth (mm/dd/yyyy)
Street Address		Primary Phone #	Work Email Address
City, State Zip	County	Secondary Phone #	Home Email Address
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Married: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Section 3: Spouse Information			
Spouse's SSN	Spouse's Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> I wish to utilize the Cross reference payment option (two KEHP members, married with children – no LRP or JRP).			
Spouse's Date of Hire/Retirement		Spouse's Organizational Unit #	Spouse's Company #
Spouse's Work Email Address		Spouse's Home Email Address	
Section 4: Dependent Information			
Child #1 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Disabled Dependent
Child #2 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Disabled Dependent
Child #3 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Disabled Dependent
Child #4 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Disabled Dependent
Child #5 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Disabled Dependent
Child #6 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Disabled Dependent
Section 5: Tobacco Use Declaration Rules governing the Tobacco Use Declaration can be found in your Benefits Selection Guide or at keh.ky.gov . You are eligible for the non-tobacco user premium contribution rates provided you certify that you or any other person to be covered under your plan has not regularly used tobacco within the past six months.			
Planholder: Within the past 6 months, have you used tobacco regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has your spouse, if covered under this plan, used tobacco regularly within the past 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have any children covered under this plan, age 18 or older, used tobacco regularly within the past 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Plan Year 2017

Employee Name:

Employee SSN:

Section 6: 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)) |
|---|--|---|---|

Section 7: Plan Options

- LivingWell CDHP
- LivingWell PPO
- Standard PPO
- Standard CDHP
- Waiver (General Purpose) HRA – with \$ (By choosing a waiver General Purpose HRA and checking this box, I declare that I and, if applicable, my spouse and my dependents, have other group health plan coverage that provides minimum value. To the extent applicable, I have listed my spouse and all dependents whose medical expenses may be reimbursed under the HRA in Sections 3 and 4 of this application.)
- Waiver Dental/Vision ONLY HRA – with \$
- Waiver without HRA – No \$
- Default Standard PPO – IC/HRG USE ONLY

Section 8: LivingWell Promise (required for selecting a LivingWell Plan)

I agree to the LivingWell Promise. Electing a LivingWell Promise plan in 2017 means you are required to complete either the Go365 Health Assessment (HA) or biometric screening from January 1, 2017 through July 1, 2017. Instructions on fulfilling your Promise can be found at LivingWell.ky.gov.

Section 9: Signatures – Please submit this application to your Company IC/HRG

By signing this application, I certify that the information provided in this application is true and correct to the best of my knowledge. I also certify that I have read, understand and agree to the Terms and Conditions of participation in the KEHP, the KEHP Legal Notices, and the Tobacco Use Declaration. These documents can be found in your Benefits Selection Guide or online at kehp.ky.gov.

By typing my name in the space provided below, I am signing this application electronically and am agreeing to conduct this transaction by electronic means.

Employee Signature _____ Date _____

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

IC/HRG Signature _____ Date _____

IC/HRG Printed Name _____ IC/HRG Phone Number _____

Spouse’s IC/HRG Signature – REQUIRED if electing the cross-reference payment option _____ Date _____

Spouse’s IC/HRG Printed Name _____ Spouse’s IC/HRG Phone Number _____