



## 2017 KEHP ACTIVE EMPLOYEE HEALTH INSURANCE QUALIFYING EVENT FORM

<b>Section 1: To Be Completed by Insurance Coordinator/HRG</b>					
KHRIS Personnel Number		Date of Hire (mm/dd/yyyy)		Coverage Effective Date (mm/dd/yyyy)	
Company Name			Company Number		Org Unit Number
<b>Section 2: Demographic Information</b>					
Employee's SSN		Name (Last, First, MI)		Employee's 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		
<b>Section 3: Change Information</b>					
Please select one QE reason and attach required documentation			Date of Event: (mm/dd/yyyy)		
<input type="checkbox"/> <b>Adding Dependents</b>			<input type="checkbox"/> <b>Dropping Dependents</b>		
Marriage		Copy of marriage certificate attached? Yes <input type="checkbox"/> No <input type="checkbox"/>		Divorce	
Birth/Adoption of Child		Copy of birth certificate or Placement documents attached? Yes <input type="checkbox"/> No <input type="checkbox"/>		Death	
Loss of Other Coverage		Letter from HR or Certificate of Prior Coverage attached? Yes <input type="checkbox"/> No <input type="checkbox"/>		Gaining Other Coverage	
Loss of KCHIP/Medicaid		MET form attached? Yes <input type="checkbox"/> No <input type="checkbox"/>		Gaining Medicare/Medicaid	
Guardianship/Court Order		Copy of Court Order attached? Yes <input type="checkbox"/> No <input type="checkbox"/>		Letter from HR or Certificate of Prior Coverage attached? Yes <input type="checkbox"/> No <input type="checkbox"/>	
				MET form attached? Yes <input type="checkbox"/> No <input type="checkbox"/>	
				Other Permitted (explain):	
<b>Section 3: Spouse Information</b>					
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 #	
<b>Section 4: Dependent Information</b>					
Child #1 SSN	Name (Last, First, MI)	<input type="checkbox"/> Natural <input type="checkbox"/> Adopted <input type="checkbox"/> Court Ordered	<input type="checkbox"/> Foster <input type="checkbox"/> Step <input type="checkbox"/> Disabled	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
Child #2 SSN	Name (Last, First, MI)	<input type="checkbox"/> Natural <input type="checkbox"/> Adopted <input type="checkbox"/> Court Ordered	<input type="checkbox"/> Foster <input type="checkbox"/> Step <input type="checkbox"/> Disabled	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
Child #3 SSN	Name (Last, First, MI)	<input type="checkbox"/> Natural <input type="checkbox"/> Adopted <input type="checkbox"/> Court Ordered	<input type="checkbox"/> Foster <input type="checkbox"/> Step <input type="checkbox"/> Disabled	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
Child #4 SSN	Name (Last, First, MI)	<input type="checkbox"/> Natural <input type="checkbox"/> Adopted <input type="checkbox"/> Court Ordered	<input type="checkbox"/> Foster <input type="checkbox"/> Step <input type="checkbox"/> Disabled	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female

Employee Name:

Employee SSN:

**Section 5: Plan Options**

Benefit Option		Coverage Level
<input type="checkbox"/> LivingWell CDHP	<input type="checkbox"/> Waiver Dental/Vision ONLY HRA	<input type="checkbox"/> Single(self only)
<input type="checkbox"/> LivingWell PPO	<input type="checkbox"/> Waiver without HRA - No \$	<input type="checkbox"/> Parent Plus (self and child(ren))
<input type="checkbox"/> Standard PPO	<input type="checkbox"/> Waiver (General Purpose) HRA*	<input type="checkbox"/> Couple (self and spouse)
<input type="checkbox"/> Standard CDHP	*For adding or deleting dependents only	<input type="checkbox"/> Family (self, spouse and child(ren))

**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))
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**Section 6: 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](http://LivingWell.ky.gov).

**Section 7: Tobacco Use Declaration** Rules governing the Tobacco Use Declaration can be found in your Benefits Selection Guide or at [kehp.ky.gov](http://kehp.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
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**Section 8: Signatures – Please submit this application to your Company Insurance Coordinator**

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](http://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 _____