



## 2017 KEHP UPDATE FORM

To be completed by Insurance Coordinator/HR Generalist only. **DO NOT** use this form to add or drop dependents.

This form is to be used to update information on health insurance, FSA and HRAs.

<b>General Information</b> (required)			
<b>Name:</b>	<b>Personnel Number:</b>	<b>SSN:</b>	
<b>Organizational Unit:</b>	<b>Company Number:</b>	<b>Company Name:</b>	
<b>Update Reason</b>			
<input type="checkbox"/> <b>Termination:</b> <b>Date Employment Ends</b> _____ <b>Date Health Insurance Terminates</b> _____ <i>Reason:</i> <input type="checkbox"/> Resigned <input type="checkbox"/> Retired <input type="checkbox"/> LWOP <input type="checkbox"/> Death <input type="checkbox"/> Military Leave <input type="checkbox"/> Other _____			
<input type="checkbox"/> <b>Reinstate Coverage:</b> <b>Date Returned to Work</b> _____ <b>Date Health Insurance Effective</b> _____ <i>Reason:</i> <input type="checkbox"/> Rehired <input type="checkbox"/> FMLA <input type="checkbox"/> LWOP <input type="checkbox"/> Military Leave <input type="checkbox"/> Other _____			
<input type="checkbox"/> <b>Transfer or Summer Transfer:</b> <b>Is member Cross Reference?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No ■ To be completed by the <b>NEW</b> company ■ No changes to current coverage allowed			
<b>Prior Company Number</b> _____		<b>New Company Number</b> _____	
<b>Last Day Worked at Prior Company</b> _____		<b>Date Hired at New Company</b> _____	
<b>Coverage End Date at Prior Company</b> _____		<b>Coverage Begin Date at New Company</b> _____	
<b>Current Health Benefit Option</b>		<b>Current Coverage Level</b>	
<input type="checkbox"/> LivingWell CDHP <input type="checkbox"/> LivingWell PPO <input type="checkbox"/> Standard PPO <input type="checkbox"/> Standard CDHP	<input type="checkbox"/> Waiver Dental/Vision ONLY HRA <input type="checkbox"/> Waiver without HRA - No \$ <input type="checkbox"/> Waiver (General Purpose) HRA	<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))	
<b>Current FSA Option</b>			
<input type="checkbox"/> Healthcare FSA <input type="checkbox"/> Dependent Care FSA Total Calendar Year Contribution: \$ _____			
<b>Other Changes or Corrections</b> For: <input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)			
<b>Name</b>	New: _____		
	Previous: _____		
<b>New Address</b> <small>(Where mail received)</small>	Street Address: _____		
	City: _____	State: _____	ZIP Code: _____
<b>E-Mail Address</b>	_____		
<b>SSN</b>	Correct: _____	Incorrect: _____	
<b>Date of Birth</b>	Correct: _____	Incorrect: _____	
<b>Other</b>			
I acknowledge and understand that DEI will comply with 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 _____			Date _____
IC/HRG Signature _____			Date _____
IC/HRG Printed Name _____			IC/HRG Phone Number _____