



## KHRIS Security Access Request Form

**Instructions: Complete form and fax to Jessie Drury at 502-564-5278.**

Company/Organization Name:	Company Number:
KHRIS Organizational Unit Number (Org. Unit):	Business Partner Number:
Requestor's Name and Title ( <i>IC or BL's manager</i> ):	Requestor's Signature:
Non-Commonwealth Paid IC/BL: <input type="checkbox"/> yes <input type="checkbox"/> no	Kentucky Group Life Only: <input type="checkbox"/> yes <input type="checkbox"/> no

*Please indicate role(s) for person below:*

**Insurance Coordinator/ Benefits Administrator:** Please choose either Primary or Secondary.

**Primary Contact**  (You can **only** have one primary IC contact per agency. If this box is checked, this person will replace the current primary IC contact for your agency and move them to secondary unless noted below to term them.)

**Secondary Contact**  (there is no limit on secondary)

**Billing Liaison:** Please choose either Primary or Secondary.

**Primary Contact**  (You can **only** have one primary BL contact per agency. If this box is checked, this person will replace the current primary BL contact for your agency and move them to secondary unless noted below to term them.)

**Secondary Contact**  (there is no limit on secondary)

**Is the employee eligible for Health Insurance Benefits?**  Yes  No

**\*\*\* If yes, the employee must complete the KEHP Active Enrollment Application**

**Grant access to: (Information below will be used for Communications with IC/BL)**

Name:	SSN:
Personnel Number:	KHRIS User ID:
Work Phone Number:	Work Fax Number:
Work E-mail Address:	IC Work Address:
Access Start Date:	

**Does this person replace someone in your agency?**  Yes  No

*If Yes, please provide the following:*

Name:	SSN, KHRIS ID or Personnel Number:
Access End Date:	

**\*\*\*All training must be completed before access is granted.\*\*\***