Retro Cap Override Form

NonCommonwealth Paid Members Only

Section I to be completed by Override Requestor

Member PRNR_____ Member SSN_____ Member Name_____

Agency Name_____ Agency 5 digit number_____

Agency Business Partner Number: _____

What type of change is requested (e.g termination, demographic data change*, plan change):

_____

Why was the change requested outside the 6 month cap?

_____

Requested by *(print)*: _____

Signature of Requestor _____ Date_____

*Demographic changes and plan retriggers without a plan change will all be automatically approved & processed.

Section II to be completed by DEI and/or KGLI KHRIS Super User

DEI

- ❑ Confirm change meets all requirements for rescission, COBRA and plan eligibility? _____
- ❑ Change Approved or Denied (circle one) Approver Initials _____

KGLI

- ❑ Confirm change meets all eligibility and regulatory requirements? _____
- ❑ Change Approved or Denied (circle one) Approval Initials _____

Super User name *(print)*: _____

Signature of Super User _____ Date _____

Comments:

Mail or fax this form with Requestor's signature to DEI and/or KGLI Super User. The Super User will notify the requestor if request approved or denied. If approved, the requestor will process the requested change.

Department of Employee Insurance fax – 502-564-1085 Kentucky Group Life fax 502-564-4034

Note to DEI/KGLI REQUESTORS All actions not originated by the member's agency IC/HRG require that agency IC/HRG to be notified.