Do Not Staple
Kentucky Employees' Health Plan
Department of Employee Insurance
www.KEHP.KY.GOV • 1-888-581-8834

2012 KEHP
ACTIVE EMPLOYEE HEALTH INSURANCE ADD/DROP FORM

Section 1: *To Be Completed by Insurance Coordinator/HR Generalist*

Employee's SSN	/ /	Employee Personnel Number		Home County Code	
Company Name			Company Number		
Date of Hire	/ /	Coverage Effective Date	/ /	Org. Unit Number	
Reason for Application	☐ Qualifying Event	☐ Other			

Section 2: *Demographic Information*

Name (Last, First, MI) _____ Date of Birth / /

Street Address _____ Home Phone Number _____ Cell Phone Number _____

City, State, ZIP _____ Home Email Address _____ Work Email Address _____

Gender ☐ Male ☐ Female

Section 3: *Change Information*

Select QE Reason Date of Event / /

Deletion of Dependent

	Divorce
	Death
	Loss of Eligibility
	Gaining Other Coverage
	Gaining Medicare/Medicaid
	Other/Reason:

Addition of Dependent

	Marriage
	Birth/Adoption of Child
	Guardianship/Court Order
	Loss of Other Coverage
	Loss of KCHIP/Medicaid
	Re-establishing Eligibility
	Special Enrollment

Section 4: *Plan Election - Only complete if QE allows Plan Option and Coverage Level changes*

Benefit Option		Coverage Level	
☐	Commonwealth Standard PPO	☐	Single (self only)
☐	Commonwealth Maximum Choice	☐	Parent Plus (self and child(ren))
☐	Commonwealth Capitol Choice	☐	Couple (self and spouse)
☐	Commonwealth Optimum PPO	☐	Family (self, spouse and child(ren))

Section 5: *Dependent Information*

Social Security Number	Name (Last, First, Middle Initial)	Birth Date MONTH/DAY/YEAR	Gender	Cross Reference Payment Option (LRP, JRP not eligible)
Spouse's		/ /	☐ Male ☐ Female	☐ Yes (Employee, Spouse & child(ren))

Note: If Cross Reference Payment Option Complete This Information on Spouse:

Spouse's Organizational Unit #: ☐ Dual Employee ☐ Hazardous Duty Date of hire/retirement ___/___/___ Has Spouse smoked in the last 2 months? ☐ Yes ☐ No

Spouse's Company #:

Child 1		___/___/___	☐ Male ☐ Female	☐ Natural ☐ Adopted ☐ Court Ordered ☐ Foster ☐ Step ☐ Disabled
Child 2		___/___/___	☐ Male ☐ Female	☐ Natural ☐ Adopted ☐ Court Ordered ☐ Foster ☐ Step ☐ Disabled
Child 3		___/___/___	☐ Male ☐ Female	☐ Natural ☐ Adopted ☐ Court Ordered ☐ Foster ☐ Step ☐ Disabled

Plan Year 2012

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Employee's SSN

Employee's Name

Authorization and Certification

I understand and agree that:

- My signature on this application creates a legal and binding contract between the Department of Employee Insurance (DEI), Kentucky Employees' Health Plan (KEHP), third-party administrators including Humana and Express Scripts, and me.
- **If my spouse and I elect the cross-reference payment option, we are planholders with Family coverage and that upon a loss of eligibility by either spouse; the remaining planholder will default to Parent Plus coverage. The cross-reference payment option ceases upon loss of eligibility or** employment by either spouse/planholder.
- I certify that each enrolled dependent meets KEHP eligibility requirements of a dependent as set forth in the Summary Plan Descriptions and in the KEHP Benefits Selection Guide. I understand that DEI requires supporting documentation to verify the eligibility of any dependent enrolled or requesting to be enrolled in the Plan. And, in addition, an affidavit **2012 Certification of Dependent Eligibility** must be submitted for dependent children between the ages of 19-26.
- All KEHP benefits for my eligible dependents and me will be provided in accordance with the Summary Plan Descriptions. I will abide by all terms and conditions governing membership and receipt of services from the plan in which I have enrolled as set forth in the Summary Plan Descriptions.
- **I have rights under HIPAA and that DEI will comply with the HIPAA rules and that disclosure of protected health 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 business associates, third party administrators,** vendors, consultants, governmental agencies 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.
- **Any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance containing any forged signature or incorrect signature date thereto commits a fraudulent insurance act, which is a crime. I understand that I can be held responsible for** any fraudulent act that is the result of a forged signature or incorrect signature date that I could have prevented while acting within my duties related to the KEHP and it may be used to reduce or deny a claim or to terminate my coverage.
- I have fully read the materials provided to me. My signature below certifies that all information, signatures and signature dates affixed to this contract are correct to the best of my knowledge.

PLEASE SUBMIT THIS APPLICATION TO YOUR COMPANY INSURANCE COORDINATOR OR HRG

Employee Signature _____ Date _____

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

Insurance Coordinator/HRG Signature _____ Date _____

Spouse's Insurance Coordinator/HRG Signature – *REQUIRED* if electing or ending the cross-reference payment option _____ Date _____