Department of Employee Insurance

Kehp.ky.gov Personnel.ky.gov

888-581-8834

**DO NOT STAPLE**

**2024 EMPLOYEE BENEFITS ENROLLMENT/CHANGE FORM**

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| **Section 1: To be completed by the IC/HRG – IN OFFICE USE ONLY** | | | | | | | | | | | | | | | | | |
| KHRIS Personnel # | Organizational  Unit # | | Cost Center # | | | | Company Name | | | | Company # | | Coverage Effective Date | | Hire/QE/Transfer/Term Date | | |
| **Reason(s) for**  **Application:**  New Hire  Rehire/Reinstate  New Group  Qualifying Event  Change or Update  ACA  Exception  Open Enrollment  Update Demographics | | | | | **Change in Employee**  **Status:**  Transfer  Begin LWOP  End LWOP  Begin Military Leave  End Military Leave  Retired  Termination  Summer Transfer | | | | **Qualifying Event:**  Marriage  Loss of Group Health  Birth/Adoption/Placement  Begin Medicare/Medicaid  Court Order for Child  End Medicare/Medicaid  Divorce  Sp/Dep Start Employment  Death  Sp/Dep Termed Employment  Loss of Individual Health Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| **Transfer from one KEHP covered entity to another KEHP covered entity:**  This section is to be completed by the **NEW** company & no changes to current coverage allowed. Prior Agency #:      Last Day Worked: | | | | | | | | |
| **Section 2: Employee Information** | | | | | | | | | | | | | | | | | |
| Employee’s SSN | | | | | | Employee Name (Last, First, MI) | | | | | | Date of Birth (mm/dd/yyyy) | | | | | |
| Mailing Address | | | | | | City, State Zip | | | | | | County | | | | | |
| Primary Phone # | | | | | | Secondary Phone # | | | | | | Email Address-Preferably Work Email | | | | | |
| Sex: Male Female | | | | | | Married: Yes No | | | | | | **Dental** Add  Drop Remain  **Vision** Add  Drop Remain | | | | | |
| **Section 3: Spouse Information** | | | | | | | | | | | | | | | | | |
| Spouse’s SSN | | | | | | Spouse’s Name (Last, First, MI) | | | | | | Date of Birth (mm/dd/yyyy) | | | | | |
| Sex: Male  Female | | | | **Health** Add  Drop Remain **Dental** Add  Drop Remain **Vision** Add  Drop Remain | | | | | | | | | | | | | |
| I wish to utilize the cross-reference payment option (two KEHP members, married with children – no LRP or JRP) | | | | | | | | | | | | | | | | | |
| Spouse’s Personnel Number | | | | Spouse’s Hire Date | | | | | | Spouse’s Organizational Unit # | | | | Spouse’s Company # | | | |
| Spouse’s Primary Phone # | | | | Spouse’s Secondary Phone # | | | | | | Spouse’s Email Address-Preferably Work Email | | | | | | | |
| **Section 4: Dependent Information** | | | | | | | | | | | | | | **Health** | | **Dental** | **Vision** |
| Child #1 SSN | | Name (Last, First, MI) | | | | | | Date of Birth (mm/dd/yyyy) | | | Male  Female  Disabled Dependent | | | Add Drop  Remain | | Add Drop  Remain | Add  Drop  Remain |
| Child #2 SSN | | Name (Last, First, MI) | | | | | | Date of Birth (mm/dd/yyyy) | | | Male  Female  Disabled Dependent | | | Add Drop  Remain | | Add Drop  Remain | Add  Drop  Remain |
| Child #3 SSN | | Name (Last, First, MI) | | | | | | Date of Birth (mm/dd/yyyy) | | | Male  Female  Disabled Dependent | | | Add Drop  Remain | | Add Drop  Remain | Add  Drop  Remain |
| Child #4 SSN | | Name (Last, First, MI) | | | | | | Date of Birth (mm/dd/yyyy) | | | Male  Female  Disabled Dependent | | | Add Drop  Remain | | Add Drop  Remain | Add  Drop  Remain |
| Child #5 SSN | | Name (Last, First, MI) | | | | | | Date of Birth (mm/dd/yyyy) | | | Male  Female  Disabled Dependent | | | Add Drop  Remain | | Add Drop  Remain | Add  Drop  Remain |
| Child #6 SSN | | Name (Last, First, MI) | | | | | | Date of Birth (mm/dd/yyyy) | | | Male  Female  Disabled Dependent | | | Add Drop  Remain | | Add Drop  Remain | Add  Drop  Remain |
| Child #7 SSN | | Name (Last, First, MI) | | | | | | Date of Birth (mm/dd/yyyy) | | | Male  Female  Disabled Dependent | | | Add Drop  Remain | | Add Drop  Remain | Add  Drop  Remain |

**Employee:**       **Employee SSN:**

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| **Section 5: Tobacco Use Declaration** Rules governing the Tobacco Use Declaration can be found online at 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? Yes No  Has your spouse, if covered under this plan, used tobacco regularly within the past 6 months? Yes  No  Have any children covered under this plan, age 18 or older, used tobacco regularly within the past 6 months? Yes No | |
| **Section 6: Health Insurance Plan Options-All plans require the LivingWell Promise to receive the monthly premium discount of $40 for the next plan year. Instructions and more information on fulfilling the LivingWell Promise can be found at livingwell.ky.gov.**  LivingWell CDHP  LivingWell PPO  LivingWell Basic CDHP  **Select a Health Premium Level**  Single (self only)  Parent Plus (self + child(ren))  Couple (self and spouse)  Family (self, spouse and child(ren))  Waiver (General Purpose) HRA – with $ (I declare that I and, if applicable, my spouse and my dependents, have other group health plan coverage that provides minimum value. To the extent applicable, I have listed my spouse and all dependents whose medical expenses can be reimbursed under the HRA in Sections 3 and 4 of this application.)  **Source of other coverage:**  Covered w/my spouse’s employer (does not include TRICARE)  Covered w/my parent’s employer  Dual group coverage/my own 2nd employer/retirement plan  **\*Note:** *if you have Medicaid, Medicare, TRICARE, Christian Healthcare Ministry, Veteran’s Benefits or Individual Coverage w/Marketplace/Exchange, you are not eligible for the Waiver GP HRA but can elect the Waiver Limited Purpose HRA***.**  Waiver Limited Purpose HRA – with $  Waiver without HRA – No $  Default LivingWell Basic CDHP (no HRA funds) – IC/HRG use ONLY – This should be used when a NEW HIRE does not submit an enrollment form or enroll online with KHRIS ESS. | |
| **Section 7: Anthem Dental Insurance Options**  Dental Bronze  Dental Silver  Dental Gold  **Select a Dental Premium Level**  Single (self only)  Parent Plus (self + child(ren))  Couple (self and spouse)  Family (self, spouse and child(ren)) *If cross-reference, please list the employee to carry the coverage* | **Section 8: Anthem Vision Insurance Options**  Vision Bronze  Vision Silver  Vision Gold  **Select a Vision Premium Level**  Single (self only)  Parent Plus (self + child(ren))  Couple (self and spouse)  Family (self, spouse and child(ren)) *If cross-reference, please list the employee to carry the coverage* |
| **Section 9: Flexible Spending Accounts** | |
| **Healthcare Flexible Spending Account**  I request to (check one)  Enroll in or  Change my Healthcare FSA for calendar year 2024. I understand that the minimum allowable contribution is $10 per month ($5 per semi-monthly period).  Total Calendar Year Contribution; divisible by 24: $  *If cross-ref, please list the amount for each employee:*  *Employee Name:* *Amount:*  *Employee Name:* *Amount:*  \*New hires should calculate year contribution from effective date to the  end of the year.  •Maximum calendar year contribution is $3,050 per eligible Planholder.  •Minimum calendar year contribution is $120 (or $10 per month).  •Maximum annual carryover amount is $610 from 2024 to 2025.  •Minimum annual carryover amount is $50. | **Child and Adult Daycare Flexible Spending Account**  I request to (check one)  Enroll in or  Change my Child and Adult Daycare FSA for calendar year 2024. I understand that the minimum allowable contribution is $10 per month ($5 per semi-monthly period).  Total Calendar Year Contribution; divisible by 24: $  *If cross-ref, please list the amount for each employee:*  *Employee Name:* *Amount:*  *Employee Name:* *Amount:*  \*New hires should calculate year contribution from effective date to the  end of the year.  •Maximum contribution per tax filing status is $2,500 married filing  separately, $5,000 married filing, or $5,000 married head of household.  •Minimum calendar year contribution is $120 (or $10 per month).  •For daycare expenses such as preschool, summer day camp, before/after school programs, and child or elder daycare. |
| **Section 10: Signatures – Please submit this application to your Company IC/HRG** 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 online at kehp.ky.gov and personnel.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 Spouse Signature-REQUIRED if electing cross-reference Date    IC/HRG Signature IC/HRG Printed Name IC/HRG Phone# Date    Spouse’s IC/HRG Signature-REQUIRED if electing cross-reference Spouse’s IC/HRG Printed Name IC/HRG Phone# Date | |