Kentucky Employees' Health Plan
Department of Employee Insurance
Kehp.ky.gov • 1.888.581.8834

DO NOT STAPLE

KENTUCKY PERSONNEL CABINET | Kentucky Employees' Health Plan

2019 EMPLOYEE HEALTH INSURANCE ENROLLMENT/CHANGE APPLICATION

Section 1: To Be Completed by IC/HRG – IN OFFICE USE ONLY

KHRIS Personnel Number	Organizational Unit #	Company Name	Hire/QE/Transfer/Term Date	Coverage Effective Date	Company #	Cost Center #

Reason(s) for Application:
- ☐ Open Enrollment
- ☐ New Hire
- ☐ Rehire
- ☐ New Group
- ☐ Qualifying Event
- ☐ Change or Update
- ☐ ACA
- ☐ Grievance

Change in Employee Status:
- ☐ Transfer
- ☐ Begin LWOP
- ☐ End LWOP
- ☐ Begin Military Leave
- ☐ End Military Leave
- ☐ Retired
- ☐ Termination

Qualifying Event:
- ☐ Marriage
- ☐ Birth/Adoption/Placement
- ☐ Court Order for Child
- ☐ Divorce
- ☐ Death
- ☐ Loss of Individual Health
- ☐ Loss of Group Health
- ☐ Begin Medicare/Medicaid
- ☐ End Medicare/Medicaid
- ☐ Spouse/Dependent Starting Employment
- ☐ Spouse/Dependent Terminating Employment
- ☐ Other:

Termination or Transfer
If transfer: This is to be completed by the **NEW** company & no changes to current coverage allowed.

Prior Company #:	Last Day worked:
☐ Healthcare FSA	☐ Dependent Care FSA
Coverage End date:	

Section 2: Demographic Information -- Changes or Current (Circle one)

Employee's SSN	Employee Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	IC/HRG Name

Street Address		Primary Phone #	Email Address - preferably Work Email for notification purposes
City, State Zip	County	Secondary Phone #	
Sex: ☐Male ☐Female		Married: ☐Yes ☐No	

Section 3: Spouse Information -- Changes or Current (Circle one)

Spouse's SSN	Spouse's Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	☐Add ☐ Drop ☐Remain	Sex ☐Male ☐ Female

☐ 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 Phone #	Spouse's Email Address - preferably Work Email for notification purposes	IC/HRG Name

Section 4: Dependent Information -- Changes or Current (Circle one)

Child #1 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	☐Male ☐Female ☐Disabled Dependent	☐Add ☐ Drop ☐Remain
Child #2 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	☐Male ☐Female ☐Disabled Dependent	☐Add ☐ Drop ☐Remain
Child #3 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	☐Male ☐Female ☐Disabled Dependent	☐Add ☐ Drop ☐Remain

Employee: **Employee SSN:**

Child #4 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	☐Male ☐Female ☐Disabled Dependent	☐Add ☐ Drop ☐Remain
Child #5 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	☐Male ☐Female ☐Disabled Dependent	☐Add ☐ Drop ☐Remain
Child #6 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	☐Male ☐Female ☐Disabled Dependent	☐Add ☐ Drop ☐Remain

Section 5: Tobacco Use Declaration Rules governing the Tobacco Use Declaration can be found in your Benefits Selection Guide or 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: Coverage Level - Note: Verification documents may be required; check with your Insurance Coordinator or HR office.

☐ Single (self only) ☐ Parent Plus (self and child(ren)) ☐ Couple (self and spouse) ☐ Family (self, spouse and child(ren))

Section 7: Plan Options – All plans require the LivingWell Promise to receive the monthly premium discount for the next plan year. Instructions on fulfilling your Promise can be found at LivingWell.ky.gov.

☐ LivingWell CDHP
☐ LivingWell PPO
☐ LivingWell Basic CDHP
☐ LivingWell Limited High Deductible
☐ 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.)
My Group Health Plan Carrier:_____ **My Group Health Plan Policy Number:**_____
☐ Waiver Dental/Vision ONLY HRA – with $
☐ Waiver without HRA – No $
☐ Default LivingWell Limited High Deductible – IC/HRG use ONLY

Section 8: 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 in your Benefits Selection Guide or online at kehp.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 | Date | IC/HRG Phone #

Spouse's IC/HRG Signature – REQUIRED if electing cross-reference | Spouse's IC/HRG Printed Name | Date | Spouse's IC/HRG Phone #

Nationwide
is on your side

Nationwide Life Insurance Company
Home Office: Columbus, Ohio

Commonwealth of Kentucky
Employee Group Life Insurance Program
Enrollment/Change/Termination and
Designation of Beneficiary Form
Group Insurance Contract: NP01002

2019 Plan Year

Please do not staple or attach other documents to this form. Please complete and print all information. Use black or blue ink only.

Application Type: ☐ New Hire ☐ Qualifying Event ☐ Open Enrollment

Company Number	Company Name (Specify name or Agency, School Board or Health Dept.)	Organizational Unit #	Cost Center #

Name (Last, First, MI)	SSN	Birthdate

Address (Street Name/Number)	Annual Salary	Hire Date	Gender ☐ Male ☐ Female

City, County, State, Zip	Work Number	Home Number

☐ **Termination:** Date Employment Ends _____ Date Life Insurance Terminates _____

Reason: ☐ Resigned ☐ Retired ☐ LWOP ☐ Death ☐ Military Leave ☐ Other_____

☐ **Reinstate Coverage:** Date Returned to Work _____ Date Insurance Effective _____

Reason: ☐ Resigned ☐ Retired ☐ LWOP ☐ Death ☐ Military Leave ☐ Other_____

☐ **Transfer or Summer Transfer** To be completed by the **NEW** company

Prior Company Number:	New Company Number:
Last Day Worked at Prior Company:	Date Hired at New Company:
Coverage End Date at Prior Company:	Coverage Begin Date at New Company:

A. Basic Life and Accidental Death and Dismemberment (AD&D) Insurance

Eligible employees are insured at no cost to the employee for Basic Life and AD&D Insurance
All Eligible Employees $20,000 Cost: (employer paid)

B. Optional Life and Accidental Death and Dismemberment (AD&D) insurance (Select One Plan)

I wish to ☐ enroll* in, ☐ change* to, ☐ terminate the optional insurance plan checked below:

Age	☐Option 1 $5,000	☐ Option 2 $10,000	☐ Option 3 $25,000	☐ Option 4 $50,000	☐ Option 5 $100,000	☐ Option 6 $150,000
Under age 40	$1.10	$2.22	$5.52	$11.04	$22.08	$33.12
Ages 40-59	$2.76	$5.52	$13.80	$27.60	$55.20	$82.80
Age 60 and over	$4.52	$9.02	$22.54	$45.08	$90.16	$135.24

*Evidence of insurability may be required depending on the circumstances.

C. Dependent Life Insurance (Select One Plan)

Please ☐ enroll* my dependents in, ☐ change* my present plan to, or ☐ terminate the plan checked below:

Qualified Dependent	☐Plan A	☐Plan B	☐Plan C	☐Plan D	☐Plan E	☐Plan F	☐Plan G	☐Plan H
Spouse**	$10,000	$5,000	$5,000	$10,000	---	$20,000	$20,000	---
Dependent Children to 6 months	$2,500	$1,500	---	---	$2,500	$2,500	---	$2,500
Dependent Children 6 months-18 years***	$5,000	$3,000	---	---	$5,000	$10,000	---	$10,000
Monthly Contribution	$10.54	$5.70	$2.42	$8.42	$3.48	$21.08	$16.82	$6.96

*Evidence of insurability may be required depending on circumstances.
**Spouse means a person to whom you are legally married.
***18 and older if attending an educational institution and relying on the employee for financial support or incapacitated and proof received within 31 days of age limit.

D. Waiver of Optional Life and Dependents Coverage

☐ I certify that I have been given the opportunity to enroll myself and my eligible dependents in the above coverage. I have declined the Optional and/or Dependents Life coverage and understand it will be necessary for me and my dependents to furnish evidence of insurability if I desire any of the above coverage in the future (other than during an open enrollment period or other exception detailed in the certificate booklet).

Nationwide
is on your side

Nationwide Life Insurance Company
Home Office: Columbus, Ohio

Commonwealth of Kentucky
Employee Group Life Insurance Program
Enrollment/Change/Termination and Designation of Beneficiary Form
Group Insurance Contract: NP01002

E. Beneficiary Designation/Change

Please complete all appropriate boxes in ink, printing legibly. If you do not designate one or more beneficiaries, policy proceeds will be paid as outlined in the Certificate of Coverage, unless otherwise regulated by law.

Basic Life and AD&D

Primary Beneficiary Information (Allocation to all Primary Beneficiaries must equal 100%)

Beneficiary Name	Address (Street, City, State, Zip)	Relationship	Date of birth	SSN	% of Benefit

Contingent Beneficiary Information (Allocation to all Contingent Beneficiaries must equal 100%)

Beneficiary Name	Address (Street, City, State, Zip)	Relationship	Date of birth	SSN	% of Benefit

Optional Life and AD&D

Primary Beneficiary Information (Allocation to all Primary Beneficiaries must equal 100%)

Beneficiary Name	Address (Street, City, State, Zip)	Relationship	Date of birth	SSN	% of Benefit

Contingent Beneficiary Information (Allocation to all Contingent Beneficiaries must equal 100%)

Beneficiary Name	Address (Street, City, State, Zip)	Relationship	Date of birth	SSN	% of Benefit

- If more room is needed to indicate additional primary or contingent beneficiaries, please attach a separate sheet and list the information indicated above for each beneficiary. Please sign and date all additional sheets as well as this original form.
- Your group life coverage is issued by Nationwide Life Insurance Company, One Nationwide Plaza, 4-06-101 Columbus, OH 43215. Please refer to the Certificate of Insurance and Insurance Contract for all plan details, including any exclusions, limitations and restrictions which may apply.

F. Fraud Warning

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

G. Employee Signature and Date (Required)

I, the undersigned, certify that I have read the completed enrollment/change/termination form and agree that all answers in this form are true and complete to the best of my knowledge and belief. I hereby authorize my employer to deduct from my paycheck or earnings the amount required to cover my share of the coverage I have selected.

Employee Signature _____ Date _____

IC Signature _____ Date _____

Send *PERSONNEL CABINET COPY TO:*

Department of Employee Insurance
Optional Insurance Branch
501 High St, 2nd Floor
Frankfort, KY 40601