**Kentucky Employees' Health Plan**
**Department of Employee Insurance**
**Enrollment Information Branch** (Fax: 502 564-1205)
KEHP.KY.GOV · 1-888-581-8834

# 2014 KEHP
# FEDERAL POST TAX REQUEST FORM

Unless a Federal Post Tax Request Form is signed, employees who qualify for pre-tax status will AUTOMATICALLY receive qualified benefits under the Commonwealth's Cafeteria Plan (paying with pre-tax dollars).

## DEMOGRAPHIC INFORMATION → Please PRINT

___ – ___ – ____ Social Security Number

__/__/____ Date of Birth (MM/DD/YYYY)

NAME (First, MI, Last)

Mailing Address

City, State, Zip Code | County of Residence | Country / Mail Code, if not USA

Planholder's HOME Phone Number | Planholder's WORK Phone Number | Planholder's Email Address

Hire Date | Employer Name

Company Number | Organizational Number | Personnel Number

## AUTHORIZATION AND CERTIFICATION

* I hereby elect to waive participation in the Qualified Benefits under the Commonwealth of Kentucky's Cafeteria Plan.
* I understand that I will not have another opportunity to participate in the Commonwealth of Kentucky's Cafeteria Plan and pay for benefits on a pre-tax basis until a subsequent open enrollment period or unless I experience a qualifying event.
* I also understand that signing this form does not cancel my health insurance coverage, only my opportunity to participate in the Federal pre-tax method of payment.
* I understand that if I have enrolled for health insurance coverage on a separate benefit enrollment form, I will pay my share of the contribution with Federal after-tax payroll deductions.

Employee Signature | Date

Please sign and date this form and give it to your payroll department.

Payroll department signature | Date