Department of Employee Insurance
Kehp.ky.gov Personnel.ky.gov
888-581-8834
DO NOT STAPLE

TEAM KENTUCKY PERSONNEL CABINET | Department of Employee Insurance

2024 KEHP SUMMER TRANSFER

To be completed by Insurance Coordinator

This form is to be used for **only Summer Transfers**.

This form is only for insurance **end dates 7/31 or 8/31** at prior agency and **begin dates 8/1 or 9/1** at new agency.
School district employees who work under a contract will be allowed to retain KEHP coverage through the summer months (July and August) provided the:

- terms of their contract are fulfilled (this is not the same as working until the last day of school); and
- premiums for the summer coverage are paid.

General Information (New agency information)

Name	Personnel Number	SSN	DOB
Mailing Address	City, State, Zip	County	
		Email Address:	
Primary Phone #	Secondary Phone #		
Organizational Unit:	Company Number:	Company Name:	Cost Center

Summer Transfer

- **This is only for transfers between Boards of Education for the summer months.**
- To be completed by the **NEW** agency Insurance Coordinator.
- No changes to current coverage allowed.
- No ½ month breaks for summer transfers.
- Do not proceed with this form if the member termed 6/30/24 and did not pay summer premiums. Submit as a regular transfer or a new hire (normal transfer rules will apply).

Note: At the end of the contract, if the employee is non-renewed or the district has issued a "pink slip" with the intention of re-hiring the employee in the fall, the same coverage extension rules apply. The employment end date (not the last day of school) will be the contract end date; and the insurance termination date will be the last day in which payment for coverage has been received.

Prior agency	New agency
Employment contract was fulfilled: ☐ **YES** ☐ **NO**	**Date hired at new company:**
Prior company number:	**Coverage begin date at new company:**
Coverage end date at prior company:	**Name of the IC who provided you the information regarding the prior agency:**
Does the employee have other dental or vision plans (non KEHP)? If yes, please provide supporting documentation showing proof of loss with the Enrollment change form showing the new elections for dental and vision only: ☐ YES ☐ NO	Supporting documentation submitted for proof of loss of coverage for dental and vision: ☐ YES ☐ NO

IC Signature ______________________ Date ______________________

IC Printed Name ______________________ IC Phone Number/Email ______________________

Insurance Coordinator/HRG: Upload through the DEI Upload Tool