 **EXCEPTION FORM**

Send through the DEI Form Upload

PLANHOLDER’S PERSONAL INFORMATION

|  |  |  |
| --- | --- | --- |
| Name and mailing address | Effective Date of Requested Change: | |
|  | Agency/Employer Name | |
| IC/HR Name | |
| Agency Number | |
|  | | Telephone No. |
| KHRIS Per Nr |
| SSN |

**EXPLAIN REASON FOR EXCEPTION REQUEST BY ANSWERING THE QUESTIONS BELOW** *(Must include the appropriate enrollment application or the exception request will not be reviewed. Be as specific as possible; the request may be denied.)*

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| --- |
| WHAT IS THE EXACT PLAN CHANGE YOU ARE REQUESTING?  WHAT EXTENUATING CIRCUMSTANCE PREVENTED YOU FROM MEETING THE INITIAL DEADLINE? |

EXPLAIN WHO IS RESPONSIBLE FOR THE EXCEPTION REQUEST *(This explanation must describe who caused the error and the specific measures that will be taken to avoid a similar issue in the future.)*

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|  |

*By signing below, I swear, or affirm, that the information provided above is accurate and complete to the best of my recollection and belief. I also hereby promise to respond to any KEHP inquiry or clarification regarding the information above, within a reasonable period of time.*

Member Printed Name Member Signature (*or e-sign by typing name*) Date

IC/HRG Printed Name IC/HRG Signature (*or e-sign by typing name*) Date

TO BE COMPLETED BY THE DEPARTMENT OF EMPLOYEE INSURANCE

Date Received:       Date of Decision:       Approved:  Denied:  Effective Date of Change:

*(Approved exceptions are effective the 1st day of the month following the signature date of the exception request)*

Reason if denied:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  | | --- | --- | | Required document(s) not attached | Request conflicts with state and/or federal laws | | Filed past 30-days of the event date | No exception to the LivingWell Promise | | No extenuating circumstance |  | | Other | | |