 **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.)*

|  |
| --- |
| 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.)*

|  |
| --- |
|  |

*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       |

 |