Kentucky Employees’ Health Plan

Department of Employee Insurance

KPPA 800-928-4646; TRS 800-618-1687; LRP/JRP 502-564-5310

 **PLAN YEAR 2025 RETIREE HEALTH INSURANCE ENROLLMENT/CHANGE FORM**

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| **Section 1: To Be Completed by Insurance Coordinator** |
| KHRIS Personnel Number      | Hazardous Duty[ ]  | Date of Retirement      | Qualifying Event Date      | Coverage Effective Date      |
| [ ]  KPPA  80000 10006416 | [ ]  TRS  85000 10006418 | [ ]  KCTCRS 81000 10006417 | [ ]  JRP86000 10006419 | [ ]  LRP87000 10006420 | [ ]  KPPA RTW  80100 10006464 |
| KPPA Only: | [ ]  KPPA - KERS | [ ]  CERS – Oth. Ag | [ ]  KPPA – SPRS |
| **Reason(s) for Application:**[ ]  Open Enrollment[ ]  New Retiree [ ]  Returning Retiree[ ]  Applicant becomes the PH [ ]  Qualifying Event[ ]  Exception[ ]  Demographic Change[ ]  Termination | **Qualifying Event:**[ ]  Marriage[ ]  Birth/Adoption/Placement [ ]  Court Order for Child [ ]  Divorce [ ]  Death – Date:       [ ]  Loss of Individual Health [ ]  Loss of Group Health [ ]  Spouse turned 65  | [ ]  Begin Medicare/Medicaid [ ]  End Medicare/Medicaid [ ]  Loss of KCHIP [ ]  Spouse/Dependent Starting Employment [ ]  Spouse/Dependent Terminating Employment[ ]  Special Enrollment[ ]  Other: | **Termination:**  |
| Coverage End date      |
| **Section 2: Demographic Information - Changes or Current (Circle one)** |
| Retiree’s SSN      | Retiree’s Name (Last, First, MI)      |  Retiree’s Date of Birth      |
| Applicant’s SSN      | Applicant’s Name (Last, First, MI) If plan holder is not the Retiree      | Applicant’s Date of Birth      |
| Mailing Address      | Primary Phone #      | Secondary Phone #      |
| City, State Zip      | Home County      | Home Email Address      |
| Sex: [ ] Male [ ] Female | Married: [ ] Yes [ ] No |
| \*\*\*Required information for processing. Are you Medicare eligible due to Social Security disability? [ ] Yes [ ] No |
| **Section 3: Spouse Information – Skip to Section 5 if electing single coverage - Changes or Current (Circle one)** |
| Spouse’s SSN      | Spouse’s Name (Last, First, MI)      | Date of Birth (mm/dd/yyyy)      | [ ] Male [ ] Female  | [ ] Add [ ]  Drop[ ] Remain |
| \*\*\*Required information for processing. Is Spouse Medicare eligible due to Social Security disability? [ ] Yes [ ] No |
| [ ]  I wish to utilize the Cross-reference payment option (two members, married with children). ***Not available to new retirees (new to KEHP) after 1/1/2025*** |
| KPPA Only: | [ ]  KPPA - KERS | [ ]  CERS – Oth. Ag | [ ]  KPPA - SPRS |
| Spouse’s Date of Hire/Retirement       | Spouse’s Organizational Unit #      | Spouse’s Company #      |
| Spouse’s Home Email Address        | Spouse’s Work Email Address       |
| **Section 4: Dependent Information -** **Changes or Current (Circle one)** | \*\*\* Required information for processing. Are any Dependents Medicare eligible due to Social Security Disability? [ ]  Yes [ ]  No | If yes, who?       |
| Child #1 SSN      | Name (Last, First, MI)      | [ ]  Natural [ ]  Foster[ ]  Adopted [ ]  Step [ ]  Court Ordered [ ]  Disabled | Date of Birth      | [ ] Male [ ] Female  | [ ] Add [ ]  Drop[ ] Remain |
| Child #2 SSN      | Name (Last, First, MI)      | [ ]  Natural [ ]  Foster[ ]  Adopted [ ]  Step [ ]  Court Ordered [ ]  Disabled | Date of Birth      | [ ] Male [ ] Female | [ ] Add [ ]  Drop[ ] Remain |
| Child #3 SSN      | Name (Last, First, MI)      | [ ]  Natural [ ]  Foster[ ]  Adopted [ ]  Step [ ]  Court Ordered [ ]  Disabled | Date of Birth      | [ ] Male[ ] Female  | [ ] Add [ ]  Drop[ ] Remain |
| Child #4 SSN      | Name (Last, First, MI)      | [ ]  Natural [ ]  Foster[ ]  Adopted [ ]  Step [ ]  Court Ordered [ ]  Disabled  | Date of Birth      | [ ] Male[ ] Female  | [ ] Add [ ]  Drop[ ] Remain |
| Child #5 SSN      | Name (Last, First, MI)      | [ ]  Natural [ ]  Foster[ ]  Adopted [ ]  Step [ ]  Court Ordered [ ]  Disabled  | Date of Birth      | [ ] Male[ ] Female  | [ ] Add [ ]  Drop[ ] Remain |
| **Retiree’s SSN:** **Applicant’s SSN:** |
| **Section 5: Tobacco Use Declaration** Rules governing the Tobacco Use Declaration can be found in your Benefits Selection Guide or at [kehp.ky.gov](https://extranet.personnel.ky.gov/Pages/healthinsurance.aspx). 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 If yes, who?  |
| **Section 6: Coverage Level – Verification documents may be required; check with your Insurance Coordinator or HR office.** ***Note: If adding newly covered dependents you will be required to provide dependent verification documents.*** |
| [ ]  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 kehp.ky.gov in the Benefits Selection Guide.** |
| [ ]  LivingWell CDHP[ ]  LivingWell PPO [ ]  LivingWell Basic CDHP[ ]  LivingWell High Deductible Health Plan[ ]  Default Waiver w/o HRA (no HRA funds) – INSURANCE COORDINATOR USE ONLY |
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| Reason for Waiving:  |

[ ]  Waive Coverage, No HRA – without $  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Section 8: Signatures – Please submit this application to your retirement agency Insurance Coordinator** – **ADDRESS BELOW**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](https://extranet.personnel.ky.gov/Pages/healthinsurance.aspx).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. |
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| Kentucky Public Pensions Authority1260 Louisville RoadFrankfort, KY 40601 | Teachers’ Retirement System479 Versailles RoadFrankfort, KY 40601 | Judicial Retirement PlanLegislators Retirement Plan305 Ann Street, Suite 302Frankfort, KY 40601 |