Department of Employee Insurance
Kentucky Employees' Health Plan and Optional Insurance Benefits
CHECKLIST FOR NEW EMPLOYEES

Name:	**Hire Date:**
Company Name:	**Company #:**

The following is a list of your rights and responsibilities regarding enrollment in the benefits offered by the Department of Employee Insurance (DEI). Read this form carefully and make sure you understand each item. You may direct your questions to your Human Resource Office/Insurance Coordinator at _____ or you may contact DEI at 888-581-8834, option 3.

As a new Employee, I understand that:

☐ I have 30 calendar days from my date of hire to make my coverage elections with DEI, which includes enrolling in a Health Insurance plan, Flexible Spending Account, Life Insurance, Dental Insurance, Vision Insurance or waive health insurance.

- I must enroll by: _____ (30 days are counted beginning with the day after my hire date).
- My Effective Date of coverage is _____

☐ I must make my insurance elections online in KHRIS ESS (preferred method) or I must complete an Employee Benefits Enrollment/Change Form and submit to my Human Resource Office/Insurance Coordinator.

☐ I have been directed to the Medical Benefits Booklets, Summary Plan Descriptions, the Summary of Benefits and Coverage and the Benefits Selection Guide, on the website at kehp.ky.gov and personnel.ky.gov, where I can find all relevant information pertaining to my coverage.

- Health Insurance coverage options include:
  - LivingWell CDHP
  - LivingWell PPO
  - LivingWell Basic CDHP
  - LivingWell High Deductible Health Plan
  - Waiver (General Purpose) HRA – with $2,100
  - Waiver Limited Purpose HRA – with $2,100
  - Waiver without HRA – no $ (funds)

NOTE: If I fail to enroll for health insurance coverage within the specified deadline, I will be automatically enrolled in the Waiver without HRA (no HRA funds).

- Dental Insurance coverage options include:
  - Bronze Dental
  - Silver Dental
  - Gold Dental
- Vision Insurance coverage options include:
  - Bronze Vision
  - Silver Vision
  - Gold Vision
- Life Insurance coverage options include: *(if your hiring agency participates with the Group Life Insurance Program offered by the state)*
  - 20,000 Basic provided by the employer – no cost to the employee
  - Optional Life and Accidental Death and Dismemberment (AD&D) Insurance
  - Dependent Life Insurance

☐ If I add dependents to my health insurance plan, I must provide verification documents for each dependent. If I do not return the documents by the deadline, the application will be rejected. It is my responsibility to get the requested verification documents to submit with the Employee Benefits Enrollment Change form.

☐ I may enroll in a Flexible Spending Account (FSA) program (if my agency participates) online in KHRIS ESS – OR I can complete an Employee Benefits Enrollment Change Form and submit to my Insurance Coordinator.

- I have been directed to the appropriate Healthcare and/or Child and Adult Daycare FSA Summary Plan Descriptions and the Benefits Selection Guides on KEHP's website at kehp.ky.gov.

☐ Once I make my elections, I cannot change those elections during the Plan Year unless I experience a valid Qualifying Event or during the next Open Enrollment Period.

- A list of Qualifying Events is available from your Human Resource Office/Insurance Coordinator or KEHP's website at kehp.ky.gov, under the Enrolling or Changing Coverage link.

☐ Retirees who return to work – please read this information carefully:

- If I am 65 or older, I have the same opportunity to enroll in insurance coverage as any other active Employee.
- If I am a KRS/TRS/Judicial Return to Work Retiree age 65 or older and/or Medicare eligible, I am not eligible to continue a Medicare supplement plan offered by one of Kentucky's retirement systems. I must call my retirement system to notify them that I have returned to work.
- If I have Medicare, I am not eligible to waive KEHP coverage and elect the Waiver General Purpose HRA unless I have other Group Health Plan Coverage (sponsored by an employer or an employer organization) that provides minimum value. I may choose a KEHP Health Insurance plan or waive coverage and elect the Waiver Limited Purpose HRA.

☐ KEHP operates as a Section 125 Cafeteria Plan that allows me to pay my portion of the Health, Dental and Vision Insurance premiums with pre-tax dollars. I understand that I will automatically be enrolled in the program by virtue of enrolling in Health Insurance, unless I sign the Post-Tax Form. *(Life insurance premiums are post-tax.)*

☐ If I experience a COBRA Qualifying Event, such as, but not limited to, termination of employment, I have the right to continue my Health, Dental or Vision Insurance at my own expense under COBRA.

Have you worked for any other company participating in any plans offered by the Department of Employee Insurance within the last 11 days?

○ Yes ○ No If yes, please give name of company and date terminated or transferred.

Company Name:_____ Date terminated or transferred: _____

Are you retired from a state-sponsored retirement system?

○ Yes ○ No If yes, please specify which retirement system: _____

I acknowledge that I have received copies of the following:

☐ Employee Benefits Enrollment/Change Application for Health, Dental, Vision and FSA (if applicable) information or KHRIS ESS online enrollment instructions

☐ Life Insurance Enrollment Application and the Life Insurance Beneficiary Designation Form

☐ Memorandum regarding Notice of Special Enrollment Rights and Women's Health and Cancer Right Act

Other _____

I certify that I have had my benefits explained and that I understand the benefits and my responsibilities.

_____ _____

Employee Signature Date

_____ _____

Company/Agency Representative Date