

**DO NOT STAPLE**

## 2026 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.

<b>General Information</b> (New agency information)			
<b>Name</b>		<b>Personnel Number</b>	<b>SSN</b>
<b>Mailing Address</b>		<b>City, State, Zip</b>	<b>County</b>
			<b>Employee Email Address:</b>
<b>Primary Phone #</b>	<b>Secondary Phone #</b>		
<b>Organizational Unit:</b>	<b>Company Number:</b>	<b>Company Name:</b>	<b>Cost Center</b>
<b>Summer Transfer</b>			
<ul style="list-style-type: none"> <li>▪ <b>This is only for transfers between Boards of Education for the summer months.</b></li> <li>▪ To be completed by the <b>NEW</b> agency Insurance Coordinator.</li> <li>▪ No changes to current coverage allowed.</li> <li>▪ No ½ month breaks for summer transfers.</li> <li>▪ <u>Do not</u> proceed with this form if the member <u>termed</u> 6/30/25 and <u>did not pay</u> summer premiums. Submit as a regular transfer or a new hire (normal transfer rules will apply).</li> </ul>			
<p><i>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.</i></p>			
<b>Prior agency</b>		<b>New agency</b>	
<b>Employment contract was fulfilled:</b> YES    NO		<b>Date hired at new company:</b>	
<b>Prior company number:</b>		<b>Coverage begin date at new company:</b>	
<b>Coverage end date at prior company:</b> 7/31    8/31		<b>Name of the IC who provided you the information regarding the prior agency:</b>	
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		Enrollment change form showing the new elections for Anthem dental and Anthem vision along with supporting documentation showing loss of coverage for other dental and vision:    YES    NO	
IC Signature _____		Date _____	
IC Printed Name _____		IC Phone Number/Email _____	