

**DO NOT STAPLE**



**2026 EMPLOYEE BENEFITS ENROLLMENT/CHANGE FORM**

**Section 1: To be completed by the IC/HRG – IN OFFICE USE ONLY**

KHRIS Personnel #	Organizational Unit #	Cost Center #	Company Name	Company Number	Coverage Effective Date	Hire/QE/Transfer/Term Date
<b>Reason(s) for Application:</b> New Hire Rehire/Reinstate New Group Qualifying Event Change or Update ACA Exception Open Enrollment Update Demographics		<b>Change in Employee Status:</b> Transfer Begin LWOP End LWOP Begin Military Leave End Military Leave Retired Termination Summer Transfer		<b>Qualifying Event:</b> Marriage Birth/Adoption/Placement Court Order for Child Divorce Death Loss of Individual Health Loss of Group Health Begin Medicare/Medicaid End Medicare/Medicaid Sp/Dep Start Employment Sp/Dep Termed Employment Other:		
<p><b>Transfer from one KEHP covered entity to another KEHP covered entity:</b> This section is to be completed by the <b>NEW</b> company &amp; no changes to current coverage allowed.</p> <p>Prior Agency #: _____ Last Day Worked: _____</p>						

**Section 2: Employee Information**

Employee's SSN	Employee Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)
Mailing Address	City, State Zip	County
Primary Phone #	Secondary Phone #	Email Address-Preferably Work Email
Sex: Male Female	Married: Yes No	<b>Anthem Dental</b> Add Drop Remain <b>Anthem Vision</b> Add Drop Remain

**Race/Ethnicity Data:** The Commonwealth of Kentucky does not discriminate on the basis of race, color, religion, sex, national origin, sexual orientation, gender identity or expression, ancestry, age, pregnancy or related medical condition, marital or familial status, disability, veteran status, political affiliation, or genetic information, in accordance with state and federal laws. **Completion of the questions below is OPTIONAL and will NOT affect the terms or conditions of your medical coverage or your eligibility for medical coverage.** The federal government strongly encourages employers and health plans to collect social data about individuals to better identify environmental and personal conditions that affect a wide range of health and quality-of-life outcomes. **This data will be kept private and used only to help the Commonwealth of Kentucky better understand how to provide healthcare services to you.** Please select the one category with which you identify:

Hispanic or Latino    White (Non-Hispanic or Latino)    Black or African American (Non-Hispanic or Latino)    Asian (Non-Hispanic or Latino)  
 Native Hawaiian or Other Pacific Islander (Non-Hispanic or Latino)    American Indian or Alaska Native (Non-Hispanic or Latino)  
 Two or More Races    Prefer Not to Answer

**Section 3: Spouse Information**

Spouse's SSN	Spouse's Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)
Sex: Male Female	Health: Add Drop Remain	Dental: Add Drop Remain    Vision: Add Drop Remain
I wish to utilize the cross-reference payment option (two members, married with children). <b>Not available for new hires hired on or after 1/1/2025.</b>		
Spouse's Personnel Number	Spouse's Hire Date	Spouse's Organizational Unit #    Spouse's Company #
Spouse's Primary Phone #	Spouse's Secondary Phone #	Spouse's Email Address-Preferably Work Email

Employee:

Employee SSN:

Section 4: Dependent Information				Health	Dental	Vision
Child #1 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	Male Female Disabled Dependent	Add Drop Remain	Add Drop Remain	Add Drop Remain
Child #2 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	Male Female Disabled Dependent	Add Drop Remain	Add Drop Remain	Add Drop Remain
Child #3 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	Male Female Disabled Dependent	Add Drop Remain	Add Drop Remain	Add Drop Remain
Child #4 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	Male Female Disabled Dependent	Add Drop Remain	Add Drop Remain	Add Drop Remain
Child #5 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	Male Female Disabled Dependent	Add Drop Remain	Add Drop Remain	Add Drop Remain
Child #6 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	Male Female Disabled Dependent	Add Drop Remain	Add Drop Remain	Add Drop Remain
Child #7 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	Male Female Disabled Dependent	Add Drop Remain	Add Drop Remain	Add Drop Remain

**Section 5: Tobacco Use Declaration** Rules governing the Tobacco Use Declaration can be found online at [kehp.ky.gov](http://kehp.ky.gov). 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

**Section 6: Health Insurance Plan Options** *All plans require the LivingWell Promise to receive the monthly premium discount of \$40 for the next plan year. Instructions and more information on fulfilling the LivingWell Promise can be found at [kehp.ky.gov](http://kehp.ky.gov) in the Benefits Selection Guide.*

LivingWell CDHP    LivingWell PPO    LivingWell Basic CDHP    LivingWell High Deductible Health Plan

**Select a Health Premium Level**    Single (self only)    Parent Plus (self + child(ren))    Couple (self and spouse)    Family (self, spouse and child(ren))

Waiver (General Purpose) HRA – with \$ (I declare that I and, if applicable, my spouse and my dependents, have other group health plan coverage that provides minimum value. To the extent applicable, I have listed my spouse and all dependents whose medical expenses can be reimbursed under the HRA in Sections 3 and 4 of this application.)

- **Source of other coverage:**    Covered w/my spouse’s employer (does not include TRICARE)    Covered w/my parent’s employer    Dual group coverage/my own 2<sup>nd</sup> employer/retirement plan

**\*Note:** *if you have Medicaid, Medicare, TRICARE, Christian Healthcare Ministry, Veteran’s Benefits or Individual Coverage w/Marketplace/Exchange, you are not eligible for the Waiver GP HRA but can elect the Waiver Limited Purpose HRA.*

Waiver Limited Purpose HRA – with \$

Waiver without HRA – No \$

Default Waiver w/o HRA (no HRA funds) – IC/HRG use ONLY – This should be used when a NEW HIRE does not submit an enrollment form or enroll online with KHRIS ESS.

Employee:

Employee SSN:

**Section 7: Anthem Dental Insurance Options**

Dental Bronze    Dental Silver    Dental Gold

**Select a Dental Premium Level**

Single (self only)    Parent Plus (self + child(ren))  
Couple (self and spouse)    Family (self, spouse and child(ren))

*If cross-reference, please list the employee to carry the coverage*

**Section 8: Anthem Vision Insurance Options**

Vision Bronze    Vision Silver    Vision Gold

**Select a Vision Premium Level**

Single (self only)    Parent Plus (self + child(ren))  
Couple (self and spouse)    Family (self, spouse and child(ren))

*If cross-reference, please list the employee to carry the coverage*

**Section 9: Flexible Spending Accounts**

**New Hire:** I request to **enroll** in an FSA. I understand that the minimum allowable contribution is \$10 per month (\$5 per semi-monthly period).

Note: All three fields must be completed for each elected FSA.	Contribution Per Paycheck	Number of Paychecks Remaining in Plan Year		Your Total Annual Election Amount
<b>Healthcare FSA</b>	\$	X (multiply)	=	\$
<b>Child &amp; Adult Daycare FSA</b>	\$	X (multiply)	=	\$

*If cross-ref, please list the amount for each employee for Healthcare FSA:*

Employee Name:                      Amount:  
Employee Name:                      Amount:

*If cross-ref, please list the amount for each employee for Child & Adult Daycare FSA:*

Employee Name:                      Amount:  
Employee Name:                      Amount:

**Qualifying Event (QE):** I request to enroll in an FSA or change my contribution amount for the remainder of the year. I understand that the minimum allowable contribution is \$10 per month (\$5 per semi-monthly period). NOTE: If you decrease the election amount due to a QE, it cannot be less than what you have used or contributed already.

Note: All three fields must be completed for each elected FSA.	Contribution Per Paycheck	Number of Paychecks Remaining in Plan Year		New Election Amount from the Effective Date
<b>Healthcare FSA</b>	\$	X (multiply)	=	\$
<b>Child &amp; Adult Daycare FSA</b>	\$	X (multiply)	=	\$

**Section 10: Signatures – Please submit this application to your Company IC/HRG** 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 online at [keh.ky.gov](http://keh.ky.gov) and [extranet.personnel.ky.gov](http://extranet.personnel.ky.gov). 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.

Employee Signature                                      Spouse Signature-REQUIRED if electing cross-reference                                      Date

IC/HRG Signature                                      IC/HRG Printed Name                                      IC/HRG Phone#                                      Date

Spouse's IC/HRG Signature-REQUIRED if electing cross-reference Spouse's                                      IC/HRG Printed Name                                      IC/HRG Phone#                                      Date