

KHRIS Security Access Request Form

This request cannot be fulfilled if the person is not in KHRIS or if we do not have an enrollment/change form on file to input into KHRIS.

***Instructions:*** *Complete form and use the DEI Upload or fax to Jennifer Thompson at* ***502-564-5278.***

|  |  |
| --- | --- |
| **Company/Organization Name:** | **Company Number:** |
| **KHRIS Organizational Unit Number (Org. Unit):** | **Business Partner Number:** |
| **Requestor's Name *(IC or BL* 's *manager*):** | **Requestor's Signature:** |
| **Requestor’s Title:** | **Kentucky Group Life Only:  Yes  No** |

|  |  |
| --- | --- |
| ***Please indicate role(s) for person below: \*\*\* Agency must have at least one person listed as primary IC and one person listed as primary BL (It can be the same person). \*\*\**** | |
| ***Insurance Coordinator/Benefits Administrator (IC):*** *Please choose either Primary or Secondary.*  **Primary Contact**  (You can ***only*** have one primary IC contact per agency. If this box is checked, this person will replace the current primary IC contact for your agency and move them to secondary unless noted below to term them.)  **Secondary Contact** (there is no limit on secondary)  ***Billing Liaison (BL):*** *Please choose either Primary or Secondary.*  **Primary Contact**  (You can ***only*** have one primary BL contact per agency. If this box is checked, this person will replace the current primary BL contact for your agency and move them to secondary unless noted below to term them.)  **Secondary Contact** (there is no limit on secondary) | |
| **Is the employee eligible for Health Insurance Benefits?  Yes**  **No**  **\*\*\*If the employee is a new hire, they must complete the Employee Benefits Enrollment Change Form even if they are ineligible for benefits*.*** | |
| ***(Information below will be used for communications with IC/BL)*** | |
| **Name:** | **SSN:** |
| **Personnel Number (PerNr):** | **KHRIS User ID:** |
| **Work Phone Number:** | **Work Fax Number:** |
| **Work E-mail Address:** | **IC Work Address:** |
| **Access Start Date:** |  |

***If you are replacing someone in your agency or changing their access to secondary, please complete the below form.***

***Please change or term access for the following IC/BL:***

|  |  |
| --- | --- |
| **Name:** | **SSN:** |
| **Company/Organizational name:** | **Company Number:** |
| ***Does the IC access need termed?*** | **Yes  No** |
| ***Does the BL access need termed?*** | **Yes  No** |
| ***Does the IC need moved to secondary IC?*** | **Yes  No** |
| ***Does the BL need moved to secondary BL?*** | **Yes  No** |

***\*\*\*All online trainings must be completed before access is granted. Do not submit applications before you receive security access.***