

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.

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| Company/Organization Name: | Company Number: |
| KHRIS Organizational Unit Number (Org. Unit): | Business Partner Number: |
| Requestor's Name and Title (<i>IC or BL's manager</i>): | Requestor's Signature: |
| Non-Commonwealth Paid IC/BL: <input type="checkbox"/> yes <input type="checkbox"/> no | Kentucky Group Life Only: <input type="checkbox"/> yes <input type="checkbox"/> no |

Please indicate role(s) for person below:

Insurance Coordinator/ Benefits Administrator: 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: 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.**

Grant access to: (Information below will be used for Communications with IC/BL)

| | |
|----------------------|------------------|
| Name: | SSN: |
| Personnel Number: | KHRIS User ID: |
| Work Phone Number: | Work Fax Number: |
| Work E-mail Address: | IC Work Address: |
| Access Start Date: | |

Does this person replace someone in your agency? Yes No

If Yes, please provide the following:

| | |
|------------------|------------------------------------|
| Name: | SSN, KHRIS ID or Personnel Number: |
| Access End Date: | |

*****All training must be completed before access is granted.*****