

**DO NOT STAPLE**

**2023 EMPLOYEE BENEFITS ENROLLMENT/CHANGE FORM**

<b>Section 1: To be completed by the IC/HRG – IN OFFICE USE ONLY</b>						
KHRIS Personnel #	Organizational Unit #	Cost Center #	Company Name	Company #	Coverage Effective Date	Hire/QE/Transfer/Term Date
<b>Reason(s) for Application:</b> <input type="checkbox"/> New Hire <input type="checkbox"/> Rehire/Reinstate <input type="checkbox"/> New Group <input type="checkbox"/> Qualifying Event <input type="checkbox"/> Change or Update <input type="checkbox"/> ACA <input type="checkbox"/> Exception <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Update Demographics		<b>Change in Employee Status:</b> <input type="checkbox"/> Transfer <input type="checkbox"/> Begin LWOP <input type="checkbox"/> End LWOP <input type="checkbox"/> Begin Military Leave <input type="checkbox"/> End Military Leave <input type="checkbox"/> Retired <input type="checkbox"/> Termination <input type="checkbox"/> Summer Transfer	<b>Qualifying Event:</b> <input type="checkbox"/> Marriage <input type="checkbox"/> Birth/Adoption/Placement <input type="checkbox"/> Court Order for Child <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Loss of Individual Health <input type="checkbox"/> Loss of Group Health <input type="checkbox"/> Begin Medicare/Medicaid <input type="checkbox"/> End Medicare/Medicaid <input type="checkbox"/> Sp/Dep Start Employment <input type="checkbox"/> Sp/Dep Termed Employment <input type="checkbox"/> Other: _____			
<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 & no changes to current coverage allowed. Prior Agency #: _____ Last Day Worked: _____						
<b>Section 2: Employee Information</b>						
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: <input type="checkbox"/> Male <input type="checkbox"/> Female		Married: <input type="checkbox"/> Yes <input type="checkbox"/> No			<b>Dental</b> <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <b>Vision</b> <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	
<b>Section 3: Spouse Information</b>						
Spouse's SSN		Spouse's Name (Last, First, MI)			Date of Birth (mm/dd/yyyy)	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		<b>Health</b> <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <b>Dental</b> <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <b>Vision</b> <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain				
<input type="checkbox"/> I wish to utilize the cross-reference payment option (two KEHP members, married with children – no LRP or JRP)						
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		
<b>Section 4: Dependent Information</b>						
Child #1 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Disabled Dependent	<b>Health</b> <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<b>Dental</b> <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<b>Vision</b> <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain
Child #2 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Disabled Dependent	<b>Health</b> <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<b>Dental</b> <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<b>Vision</b> <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain
Child #3 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Disabled Dependent	<b>Health</b> <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<b>Dental</b> <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<b>Vision</b> <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain
Child #4 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Disabled Dependent	<b>Health</b> <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<b>Dental</b> <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<b>Vision</b> <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain
Child #5 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Disabled Dependent	<b>Health</b> <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<b>Dental</b> <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<b>Vision</b> <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain
Child #6 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Disabled Dependent	<b>Health</b> <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<b>Dental</b> <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<b>Vision</b> <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain
Child #7 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Disabled Dependent	<b>Health</b> <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<b>Dental</b> <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<b>Vision</b> <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain

Employee:

Employee SSN:

**Section 5: Tobacco Use Declaration** Rules governing the Tobacco Use Declaration can be found online at 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 livingwell.ky.gov.**

LivingWell CDHP  LivingWell PPO  LivingWell Basic CDHP

**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 LivingWell Basic CDHP (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.

**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**

**Healthcare Flexible Spending Account**

I request to (check one)  Enroll in or  Change my Healthcare FSA for calendar year 2023. I understand that the minimum allowable contribution is \$10 per month (\$5 per semi-monthly period).

Total Calendar Year Contribution; divisible by 24: \$ \_\_\_\_\_

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

Employee Name: \_\_\_\_\_ Amount: \_\_\_\_\_

Employee Name: \_\_\_\_\_ Amount: \_\_\_\_\_

\*New hires should calculate year contribution from effective date to the end of the year.

- Maximum calendar year contribution is \$2,850 per eligible Planholder.
- Minimum calendar year contribution is \$120 (or \$10 per month).
- Maximum annual carryover amount is \$570.
- Minimum annual carryover amount is \$50.

**Child and Adult Daycare Flexible Spending Account**

I request to (check one)  Enroll in or  Change my Child and Adult Daycare FSA for calendar year 2023. I understand that the minimum allowable contribution is \$10 per month (\$5 per semi-monthly period).

Total Calendar Year Contribution; divisible by 24: \$ \_\_\_\_\_

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

Employee Name: \_\_\_\_\_ Amount: \_\_\_\_\_

Employee Name: \_\_\_\_\_ Amount: \_\_\_\_\_

\*New hires should calculate year contribution from effective date to the end of the year.

- Maximum contribution per tax filing status is \$2,500 married filing separately, \$5,000 married filing, or \$5,000 married head of household.
- Minimum calendar year contribution is \$120 (or \$10 per month).
- For daycare expenses such as preschool, summer day camp, before/after school programs, and child or elder daycare.

**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 kehp.ky.gov and 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 \_\_\_\_\_