



Plan Year 2025 RETIREE HEALTH INSURANCE ENROLLMENT/CHANGE FORM

Section 1: To Be Completed by Insurance Coordinator

KHRIS Personnel Number	Hazardous Duty <input type="checkbox"/>	Date of Retirement	Qualifying Event Date	Coverage Effective Date
<input type="checkbox"/> KPPA 80000 10006416	<input type="checkbox"/> TRS 85000 10006418	<input type="checkbox"/> KCTCRS 81000 10006417	<input type="checkbox"/> JRP 86000 10006419	<input type="checkbox"/> LRP 87000 10006420
<input type="checkbox"/> KPPA RTW 80100 10006464				
KPPA Only: <input type="checkbox"/> KPPA-KERS		<input type="checkbox"/> CERS - Oth.Ag		<input type="checkbox"/> KPPA-SPRS
Reason(s) for Application:		Qualifying Event:		Termination:
<input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Retiree <input type="checkbox"/> Returning Retiree <input type="checkbox"/> Applicant becomes the PH <input type="checkbox"/> Qualifying Event <input type="checkbox"/> Exception <input type="checkbox"/> Demographic Change <input type="checkbox"/> Termination		<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 - Date: _____ <input type="checkbox"/> Loss of Individual Health <input type="checkbox"/> Loss of Group Health <input type="checkbox"/> Spouse turned 65		<input type="checkbox"/> Begin Medicare/Medicaid <input type="checkbox"/> End Medicare/Medicaid <input type="checkbox"/> Loss of KCHIP <input type="checkbox"/> Spouse/Dependent Starting Employment <input type="checkbox"/> Spouse/Dependent Terminating Employment <input type="checkbox"/> Special Enrollment <input type="checkbox"/> Other:
Coverage End Date				

Section 2: Demographic Information - Changes or Current (Circle one)

Retiree's SSN	Retiree's Name (Last, First, MI)	Retiree's Date of Birth
Applicant's SSN	Applicant's Name (Last, First, MI) <i>if plan holder is not the Retiree</i>	Applicant's Date of Birth
KPPA will update contact information for your retirement account based on the details provided below.		
Mailing Address	Primary Phone #	Secondary Phone #
City, State, ZIP	Home County	Home Email Address
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Married: <input type="checkbox"/> Yes <input type="checkbox"/> No

***Required information for processing. Are you Medicare eligible due to Social Security disability? Yes No

Section 3: Spouse Information - Skip to Section 5 if electing single coverage - Changes or Current (Circle one)

Spouse's SSN	Spouse's Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Male	<input type="checkbox"/> Add <input type="checkbox"/> Drop
			<input type="checkbox"/> Female	<input type="checkbox"/> Remain
***Required information for processing. Is Spouse Medicare eligible due to Social Security disability? <input type="checkbox"/> Yes <input type="checkbox"/> No				
<input type="checkbox"/> I wish to utilize the Cross-reference payment option (two KEHP members, married with children). <i>Not available to new retirees (new to KEHP) after 1/1/2025</i>				
KPPA Only: <input type="checkbox"/> KPPA-KERS		<input type="checkbox"/> CERS - Oth.Ag		<input type="checkbox"/> KPPA-SPRS
Spouse's Date of Hire/Retirement	Spouse's Organizational Unit #	Spouse's Company #		
Spouse's Home Email Address		Spouse Work Email Address		

Section 4: Dependent Information Changes or Current (Circle one) ***Required information for processing: Are any dependents Medicare eligible due to Social Security disability? Yes No *if yes, who?*

Child #	SSN	Name (Last, First, MI)	Natural	Adopted	Court Ordered	Foster	Step	Disabled	Date of Birth	Male	Female	Add	Drop	Remain
Child #1			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child #2			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child #3			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child #4			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child #5			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Retiree's SSN: _____

Applicant's SSN: _____

Section 5: Tobacco Use Declaration Rules governing the Tobacco Use Declaration can be found in your Benefits Selection Guide or 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has your spouse, if covered under this plan, used tobacco regularly within the past 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have any children covered under this plan age 18 or older used tobacco regularly within the past 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who? _____
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Section 6: Coverage Level - Verification documents may be required; check with your Insurance Coordinator or HR office.
Note: If adding newly covered dependents you may be required to provide verification documents.

<input type="checkbox"/> Single (self only)	<input type="checkbox"/> Parent Plus (self and child(ren))	<input type="checkbox"/> Couple (self and spouse)	<input type="checkbox"/> Family (self, spouse and child(ren))
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Section 7: Plan Options - All plans require the LivingWell Promise to receive the monthly premium discount for the next plan year. Instructions on fulfilling your Promise can be found at kehp.ky.gov in the benefits selection guide.

<input type="checkbox"/> LivingWell CDHP	<input type="checkbox"/> LivingWell PPO	<input type="checkbox"/> LivingWell Basic CDHP	<input type="checkbox"/> LivingWell High Deductible Health Plan	<input type="checkbox"/> Default LivingWell Basic CDHP (no HRA funds) - INSURANCE COORDINATOR USE ONLY	<input type="checkbox"/> Waive Coverage, No HRA - without \$	Reason for Waiving: _____
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Section 8: Signatures - Please submit this application to your retirement agency Insurance Coordinator - ADDRESS BELOW 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 in your benefits Selection Guide or online at kehp.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.

The electronic signature must be in the following format: "/s/ First-Name Last-Name".

Applicant Signature - if plan holder is not the retiree	Date
Employee/Retiree Signature	Date
Spouse Signature - REQUIRED if electing the cross-reference payment option	Date
IC/HRG Signature	Date
IC/HRG Printed Name	IC/HRG Phone Number
Spouse's IC/HRG Signature - REQUIRED if electing the cross-reference payment option	Date
Spouse's IC/HRG Printed Name	Spouse's IC/HRG Phone Number

Kentucky Public Pensions Authority 1260 Louisville Road Frankfort, KY 40601	Teachers' Retirement Systems 479 Versailles Road Frankfort, KY 40601	Judicial Retirement Plan Legislators Retirement Plan 305 Ann Street, Suite 302 Frankfort, KY 40601
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