



**2019 RETIREE HEALTH INSURANCE ENROLLMENT/ CHANGE APPLICATION**

**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"/> KRS 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
KRS Only: <input type="checkbox"/> KRS-KERS		<input type="checkbox"/> CERS - Oth.Ag		<input type="checkbox"/> KRS-SPRS
<b>Reason(s) for Application:</b>		<b>Qualifying Event:</b>		
<input type="checkbox"/> New Retiree <input type="checkbox"/> Returning Retiree <input type="checkbox"/> Return to Work Retiree <input type="checkbox"/> Qualifying Event <input type="checkbox"/> Change or Update <input type="checkbox"/> Grievance		<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"/> 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		

**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
Street Address	Primary Phone #	Secondary Phone #
City, State, ZIP	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? <input type="checkbox"/> Yes <input type="checkbox"/> 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)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
***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 - no LRP or JRP).			
KRS Only: <input type="checkbox"/> KRS-KERS		<input type="checkbox"/> CERS - Oth.Ag	
Spouse's Date of Hire/Retirement		Spouse's Organizational Unit #	
Spouse's Home Email Address		Spouse's Company #	
Spouse's Home Email Address		Spouse Work Email Address	

**Section 4: Dependent Information Changes or Current (Circle one)**

<b>Section 4: Dependent Information Changes or Current (Circle one)</b>		***Required information for processing: Are any dependents Medicare eligible due to Social Security disability? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, who?	
Child #1 SSN	Name (Last, First, MI)	<input type="checkbox"/> Natural <input type="checkbox"/> Adopted <input type="checkbox"/> Court Ordered	<input type="checkbox"/> Foster <input type="checkbox"/> Step <input type="checkbox"/> Disabled	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain
Child #2SSN	Name (Last, First, MI)	<input type="checkbox"/> Natural <input type="checkbox"/> Adopted <input type="checkbox"/> Court Ordered	<input type="checkbox"/> Foster <input type="checkbox"/> Step <input type="checkbox"/> Disabled	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain
Child #3 SSN	Name (Last, First, MI)	<input type="checkbox"/> Natural <input type="checkbox"/> Adopted <input type="checkbox"/> Court Ordered	<input type="checkbox"/> Foster <input type="checkbox"/> Step <input type="checkbox"/> Disabled	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain
Child #4 SSN	Name (Last, First, MI)	<input type="checkbox"/> Natural <input type="checkbox"/> Adopted <input type="checkbox"/> Court Ordered	<input type="checkbox"/> Foster <input type="checkbox"/> Step <input type="checkbox"/> Disabled	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain

Retiree's SSN: \_\_\_\_\_

Applicant's SSN: \_\_\_\_\_

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

**Section 5: Tobacco Use Declaration** Rules governing the Tobacco Use Declaration can be found in your Benefits Selection Guide or at [kehpcy.gov](http://kehpcy.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
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**Section 6: Coverage Level - Note: Verification documents may be required; check with your Insurance Coordinator or HR office.**

<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 [LivingWell.ky.gov](http://LivingWell.ky.gov)**

LivingWell CDHP  
 LivingWell PPO  
 LivingWell Basic CDHP  
 LivingWell Limited High Deductible  
 LivingWell Limited High Deductible - INSURANCE COORDINATOR USE ONLY  
 Waive Coverage, No HRA - without \$ \_\_\_\_\_ Reason for Waiving: \_\_\_\_\_

**Section 8: Signatures - Please submit this application to your Company 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 [kehpcy.gov](http://kehpcy.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/Retiree Signature	Date
Applicant Signature - if plan holder is not the retiree	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 Retirement Systems 1260 Louisville Road Frankfort, KY 40601	Teachers' Retirement Systems 479 Versailles Road Frankfort, KY 40601	LRP/JRP 305 Ann Street Frankfort, KY 40601
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