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Kentucky Employees' Health Plan
Department of Employee Insurance
kyret.ky.gov | 1-888-581-8834

Print Form

Form 6200
Revised 09/2014

2015 RETIREE HEALTH INSURANCE ENROLLMENT/CHANGE APPLICATION

Section 1: To Be Completed by Insurance Coordinator

KHRIS Personnel Number	Hazardous Duty ☐	Coverage Effective Date

KRS	KTRS	KCTCS	JRP	LRP
☐ 80000 10006416	☐ 85000 10006418	☐ 81000 10006417	☐ 86000 10006419	☐ 87000 10006420

Reason for Application
☐ New Retiree ☐ Open Enrollment ☐ Qualifying Event (QE) ☐ Other

Qualifying Event Date

Deletion of Dependent
☐ Divorce
☐ Death
☐ Loss of Eligibility
☐ Gaining other Coverage
☐ Gaining Medicare/Medicaid
☐ Other_____

Addition of Dependent
☐ Marriage
☐ Birth/Adoption
☐ Guardianship/Court Order
☐ Loss of Other Coverage
☐ Loss of KCHIP/Medicaid
☐ Re-establishing Eligibility
☐ Special Enrollment

Section 2: Demographic Information

Retiree's SSN	Retiree Name (Last, First, MI)	Retiree Date of Birth
Applicant's SSN	Applicant Name (Last, First, MI)	Applicant's Date of Birth

Street Address	Home County	Home Phone Number	Home Email Address
City, State, ZIP		Cell Phone Number	Gender ☐ Male ☐ Female / Married ☐ Yes ☐ No

Are you Medicare eligible due to Social Security Disability? ☐ Yes ☐ No

Within the past 6 months, have you, or a spouse or dependent(s) 18 or over, to be covered under your insurance plan, used tobacco regularly? ☐ Yes ☐ No

Section 3: Spouse/Dependent Information - Skip to Section 4 if electing single coverage.

Spouse's Information

Social Security Number	Name (Last, First, MI)	Date of Birth	Gender ☐ Male ☐ Female

Is Spouse Medicare eligible due to Social Security Disability? ☐ Yes ☐ No

Questions below only apply if you are electing the Cross-Reference Payment Option ONLY (LRP, JRP not eligible)

1. Do you and your spouse utilize the cross-reference payment option? (two KEHP members, married with child(ren))? ☐ Yes
2. Within the past 6 months, have you, the spouse, used tobacco regularly? ☐ Yes ☐ No

3. Date of Hire/Retirement	4. Organizational Unit #	5. Spouse's Company Name	6. Spouse's Company Number

Dependent(s) Information - If you need additional room for dependents, add them to another page and include it as part of the application

Child 1 Social Security Number	Name (Last, First, MI)	☐ Natural ☐ Adopted ☐ Court Ordered	☐ Foster ☐ Step ☐ Disabled	Date of Birth	Gender ☐ Male ☐ Female
Child 2 Social Security Number	Name (Last, First, MI)	☐ Natural ☐ Adopted ☐ Court Ordered	☐ Foster ☐ Step ☐ Disabled	Date of Birth	Gender ☐ Male ☐ Female
Child 3 Social Security Number	Name (Last, First, MI)	☐ Natural ☐ Adopted ☐ Court Ordered	☐ Foster ☐ Step ☐ Disabled	Date of Birth	Gender ☐ Male ☐ Female

Are any dependents Medicare eligible due to Social Security Disability? ☐ Yes ☐ No | If yes, who?

Retiree's SSN | Applicant's SSN

Section 4: Plan Options		
☐ LivingWell CDHP	---------->	☐ I AGREE to the LivingWell Promise
☐ LivingWell PPO	---------->	☐ I AGREE to the LivingWell Promise

If you do NOT AGREE to the LivingWell Promise, or if you failed to fulfill your LivingWell Promise in 2014, you must select a Standard plan option below

☐ Standard PPO
☐ Standard CDHP

Section 5: Coverage Levels			
☐ Single (self only)	☐ Parent Plus (self and child(ren))	☐ Couple (self and spouse)	☐ Family (self, spouse and child(ren))

Section 6: Waiving Health Insurance (no health insurance)	
☐ No HRA - waiving insurance/not eligible/no employer-funding.	Reason for waiving?

TOBACCO USE DECLARATION

The Commonwealth of Kentucky is committed to fostering and promoting wellness and health in the workforce. As a part of the KEHP wellness program, KEHP provides a monthly discount in premium contribution rates for non-tobacco users. 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.

TOBACCO USE INFORMATION

***Check the applicable box below*:**

Within the past six months, have you, or a spouse or dependent to be covered under your insurance plan, used tobacco regularly?

☐ **Yes** ☐ **No**

NOTE: Regularly means tobacco has been used four or more times per week on average excluding religious or ceremonial uses.

NOTE: "Tobacco" means all tobacco products including, but limited to, cigarettes, pipes, chewing tobacco, snuff, dip, and any other tobacco products regardless of the frequency or method of use.

NOTE: "Dependent" means, for the purpose of the Tobacco Use Declaration, only those dependents who are 18 years of age or older.

By submitting this form, I certify the following:

1. I have truthfully checked the Yes or No box above that accurately reflects the use of tobacco products in the past six months regarding myself and persons to be covered as a spouse or dependent under my insurance plan.
2. I understand that the tobacco-user premium contribution rates will apply beginning January 1, 2015 if I answered “Yes” to the question above.
3. I understand that it is my responsibility to notify KEHP of any changes in my tobacco-use or that of my spouse or a dependent covered under my insurance plan, including notification to KEHP if all tobacco users become ineligible for coverage or are otherwise terminated during the plan year. Notification shall be made by completing a Tobacco Use Change Form.
4. I understand that if I or a spouse or dependent to be covered under my insurance plan currently use tobacco products and stop using tobacco products during the plan year, I will be eligible for the discount non-tobacco premium contribution rates on the first day of the month following the signature date on the Tobacco Use Change Form certifying that neither I nor my spouse/dependent(s) regularly used tobacco products during the six months prior to completion of the Tobacco Use Change Form.
5. I understand that if I answered “No” to the question above and either I or a spouse or dependent covered under my insurance plan become a regular tobacco user at any time, I must notify KEHP and my contribution rates will be adjusted to the tobacco-user premium contribution rates on the first day of the month following the signature date on the Tobacco Use Change Form.
6. I understand that this Tobacco Use Declaration is a part of my KEHP application for health insurance coverage. Any person who knowingly, and with the intent to defraud files an application for insurance containing any materially false information, of who conceals, for the purposes of misleading, information concerning any fact material to the application, commits a fraudulent insurance act which is a crime.
7. I understand that if I fail to complete this Declaration truthfully, KEHP may adjust my contribution rates retroactively to apply the applicable higher tobacco-user premium contribution rates. Upon written notification, I will pay to KEHP the difference between the tobacco-user and the non-tobacco user premium contribution rates for the period for which I falsely certified eligibility for the non-tobacco user premium contribution rates.
8. The KEHP offers monthly discounted premium contribution rates to non-tobacco users as a part of its wellness program. Each KEHP member has at least one opportunity per plan year to qualify for the discount. KEHP is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact the Department of Employee Insurance at (888) 581-8834 or (502) 564-6534 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Retiree's SSN

Applicant's SSN

Authorization and Certification for elections made by the planholder for health insurance coverage through the Kentucky Employees' Health Plan (KEHP or Plan), administered by the Department of Employee Insurance (DEI). My signature on this application for health insurance creates a legal and binding contract. By affixing my signature, I understand that:

- If I am electing a KEHP plan option during open enrollment, the plan will be effective January 1 of the following plan year. If I am a new retiree electing a KEHP plan option outside of open enrollment, my plan will be effective upon my retirement and in accordance with my Retirement System's new retiree health insurance coverage rules.
- I have read and understand the 2015 KEHP Benefits Selection Guide (BSG). Plan rules and limitations are contained in the KEHP Summary Plan Descriptions (SPD) and the Summary of Benefits and Coverage (SBC).
- All KEHP benefits for my eligible dependents and me will be provided in accordance with the limitations in the SPDs, BSG, and SBCs. I will abide by all terms and conditions governing membership and receipt of services from the Plan in which I have enrolled and as set forth in the SPD. In the event of a conflict between the terms of coverage stated in the SPDs, the BSG, and the SBCs, the terms of coverage stated in the SPDs will govern.
- KEHP uses third parties, including **Anthem and CVS Caremark and WageWorks** to provide certain administrative functions. KEHP may communicate with me directly or through these third parties about my coverage, my benefits, or health-related products or services provided by, or included in KEHP's plan of benefits.
- If my spouse and I elect the cross-reference payment option, we are planholders with family coverage, and upon a loss of eligibility by either spouse, the remaining planholder will default to a parent plus coverage level. The cross-reference payment option ceases upon loss of eligibility or employment by either spouse/planholder. **(This option is not available to LRP/JRP retirees).**
- I certify that each enrolled dependent meets KEHP eligibility requirements of a dependent as set forth in the SPD and in the BSG. DEI may require supporting documentation to verify the eligibility of any dependent enrolled or requesting to be enrolled in the Plan.
- The elections indicated by this application may not be changed or cancelled during the plan year without a permitted Qualifying Event.
- I authorize my Retirement System to deduct from my earnings/benefits and/or bill me the amount required to cover my share of the premium contribution for the plan(s) I have selected, including any arrears I may owe.
- I authorize KEHP to release my medical claims data to my Retirement System for use in data analysis and referral to available health related services upon their review.
- Any premium payment submitted to KEHP that I intend to be used to pay for my health insurance premium contributions will first be used to pay other priority debts that may be due and owing such as taxes and child support.
- I authorize my Retirement System to release the information in this application to the Social Security Administration. The information in this application may be used by the Social Security Administration to determine Medicare eligibility. I further acknowledge that Medicare eligibility will affect my participation in KEHP. I acknowledge that I have an ongoing affirmative duty to inform my Retirement System of any change in Medicare eligibility status for myself, my spouse, or my dependent(s).
- Generally, the four KEHP plan options must pay primary to Medicare. If I am retired and have Medicare as well as a group health plan from a former employer, Medicare will pay primary to my group health plan coverage.
- If my KEHP plan option includes a Health Reimbursement Account (HRA), my HRA may only reimburse me for medical expenses, as authorized by 26 U.S.C. Sections 105(b) and 213(d), that are incurred during the applicable coverage period. Pursuant to federal law, the cost of over-the-counter medicines (other than insulin and those prescribed by a doctor) may not be reimbursed through my HRA. I have a 90-day run-out period (until March 31) for reimbursement of eligible HRA expenses incurred during my period of coverage.
- Any unused amount remaining in my HRA at the end of the plan year may be carried forward to the next plan year.
- WageWorks will administer HRAs for the 2015 plan year and will issue to me a WageWorks Healthcare Card for the payment of HRA expenses. My WageWorks Healthcare Card will be suspended if the required HRA claim verification is not sent to WageWorks within ninety (90) days after the card swipe. I agree to follow all rules and guidelines established by the Plan concerning the WageWorks Healthcare Card. The Plan reserves the right to deny access to the card, require repayment, deduct/withhold from my earnings, and offset my HRA if I fail to properly substantiate a claim.
- The KEHP offers discounted premium contribution rates to non-tobacco users as a part of its wellness program. If either I or a spouse or dependent to be covered under my insurance plan have used tobacco regularly within the past six months, I will not qualify for the discounted premium contribution rates. Each KEHP member has at least one opportunity per plan year to qualify for the discount. KEHP is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees/retirees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact the Department of Employee Insurance at 888-581-8834 or 502-564-6534 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.
- If I have chosen one of the KEHP LivingWell plan options, I agree to complete the KEHP LivingWell Promise by (1) completing my online Humana*Vitality* Health Assessment; OR (2) VitalityCheck (biometric screening). If I am choosing a LivingWell plan option during open enrollment, I will complete the Health Assessment OR VitalityCheck (biometric screening) from January 1, 2015 – May 1, 2015. If I am a new retiree and I choose a LivingWell plan option outside of open enrollment, I will complete the Health Assessment or VitalityCheck (biometric screening) within 90 days of my coverage effective date.
- I have rights under HIPAA regarding the protection of my health information. KEHP will comply with the HIPAA privacy and security rules, and uses and disclosures of my protected health information will be in accordance with federal law. KEHP may use and disclose such information to business associates or other third parties only in accordance with KEHP's Notice of Privacy Practices available at kehp.ky.gov.
- Any person who knowingly, and with the intent to defraud, files an application for insurance containing any materially false information (including a forged signature or incorrect signature date), or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime. I can be held responsible for any fraudulent act that I could have prevented while acting within my duties related to the KEHP, and it may be used to reduce or deny a claim or to terminate my coverage.
- I have fully read the materials provided to me. I further acknowledge that Medicare eligibility will affect my participation in KEHP. My signature on this application for health insurance certifies that all information provided during this enrollment opportunity is correct to the best of my knowledge.

Retiree's SSN

Applicant's SSN

Application MUST be signed by retirement Insurance Coordinator. Please mail application to:

KY Retirement Systems(KRS)
Perimeter Park West
1260 Louisville Road
Frankfort, KY 40601

KY Teachers' Retirement(KTRS)
479 Versailles Road
Frankfort, KY 40601

KY Judicial Form Retirement System (JRP/LRP)
305 Ann Street, Room 302,
Whitaker Bank Bldg.
Frankfort, KY 40601

KCTCS Retirees
300 North Main Str.
Versailles, KY 40383

Retiree Signature

Date

Applicant Signature (if other than retiree)

Date

Spouse's Signature*

Date

Retiree's Insurance Coordinator's Signature

Date

Spouse's Insurance Coordinator's Signature*

Date

*Required if electing the cross-payment reference option.