



2016 RETIREE HEALTH INSURANCE ENROLLMENT/CHANGE APPLICATION

Section 1: To Be Completed by Insurance Coordinator					
KHRIS Personnel Number		Hazardous Duty <input type="checkbox"/>		Coverage Effective Date	
<input type="checkbox"/> KRS 80000 10006416	<input type="checkbox"/> KTRS 85000 10006418	<input type="checkbox"/> KCTCS 81000 10006417	<input type="checkbox"/> JRP 86000 10006419	<input type="checkbox"/> LRP 87000 1006420	
Reason for Application <input type="checkbox"/> New Retiree <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Qualifying Event (QE) <input type="checkbox"/> Other				Qualifying Event Date	
Deletion of Dependent			Addition of Dependent		
<input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Loss of Eligibility			<input type="checkbox"/> Gaining other Coverage <input type="checkbox"/> Gaining Medicare/Medicaid <input type="checkbox"/> Other _____		
			<input type="checkbox"/> Marriage <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Guardianship/Court Order		
			<input type="checkbox"/> Loss of Other Coverage <input type="checkbox"/> Loss of KCHIP/Medicaid <input type="checkbox"/> Re-establishing Eligibility <input type="checkbox"/> 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	Primary Phone Number	Home Email Address	
City, State, ZIP			Secondary Phone Number	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	Married Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you Medicare eligible due to Social Security Disability? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Within the past 6 months, have you, or a spouse or dependent(s) age 18 and over, to be covered under your insurance plan, used tobacco regularly? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Section 3: Spouse/Dependent Information – Skip to Section 4 if electing single coverage.					
Social Security Number		Name (Last, First, MI)		Date of Birth	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>
Is Spouse Medicare eligible due to Social Security Disability? Yes <input type="checkbox"/> No <input type="checkbox"/>					
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 <input type="checkbox"/>					
2. Within the past 6 months, have you, the spouse, used tobacco regularly? Yes <input type="checkbox"/> No <input type="checkbox"/>					
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 as part of the application.					
Child 1 Social Security Number	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	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>
Child 2 Social Security Number	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	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>
Child 3 Social Security Number	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	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>
Are any Dependents Medicare eligible due to Social Security Disability? Yes <input type="checkbox"/> No <input type="checkbox"/>			If yes, who?		

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Retiree's SSN

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Applicant's SSN

Section 4: Plan Options	
<input type="checkbox"/> LivingWell CDHP	<input type="checkbox"/> I AGREE to the LivingWell Promise
<input type="checkbox"/> LivingWell PPO	<input type="checkbox"/> 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 2015, you must select a Standard plan option below	
<input type="checkbox"/> Standard PPO	
<input type="checkbox"/> Standard CDHP	
Section 5: Coverage Levels	
<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))
Section 6: Waiving Health Insurance (no health insurance)	
<input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/>
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 not 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:

- 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.
- I understand that the tobacco-user premium contribution rates will apply beginning January 1, 2016 if I answered "Yes" to the question above.
- 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.
- 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.
- 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.
- 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, or who conceals, for the purpose of misleading, information concerning any fact material to the application, commits a fraudulent insurance act which is a crime.
- 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.
- 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.

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Retiree's SSN

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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 and agree 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, the plan will be effective upon my retirement and in accordance with my Retirement Systems' new retiree health insurance coverage rules.
- I have read and understand the 2016 KEHP Benefits Selection Guide (BSG). Plan rules and limitations are contained in the KEHP Summary Plan Descriptions (SPD) or Medical Benefit Booklets (MBB) 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, MBBs, 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 and MBB. In the event of a conflict between the terms of coverage stated in the SPDs, the MBBs, the BSG, and the SBCs, the terms of coverage stated in the SPDs and/or MBBs will govern.
- KEHP uses third parties, including Anthem, 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's dependent eligibility requirements as set forth in the SPD and/or the MBB. 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 option 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 may 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).
- If I elect to waive KEHP health insurance coverage, without a Waiver Health Reimbursement Arrangement (HRA), I am doing so voluntarily.
- KEHP provides plan options that, under the Affordable Care Act, constitute minimum essential coverage that is affordable and provides a minimum value. For certain types of coverage, including retiree health coverage offered by a former employer, if you are eligible but not enrolled, you can still qualify for premium tax credits through kynect, the Kentucky marketplace.
- The four KEHP plan options must pay primary to Medicare.
- 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 employee 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. KEHP does not collect or retain personal health or medical information through its wellness program; however, KEHP may receive aggregate information that does not identify any individual in order to design and offer health programs aimed at improving the health of KEHP members.
- If I have chosen one of the KEHP LivingWell plan options, I agree to fulfill the KEHP LivingWell Promise by completing (1) my online HumanaVitality Health Assessment; OR (2) a VitalityCheck (biometric screening). If I am choosing a LivingWell plan option during open enrollment, I will complete the Health Assessment OR a VitalityCheck (biometric screening) from January 1, 2016 through May 1, 2016. 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. My signature on this application certifies that all information provided during this enrollment opportunity is correct to the best of my knowledge.
- Exceptions may apply to employees of certain employers participating in KEHP and to KTRS, KRS, LRP, and JRP retirees. Please refer to the participation rules of your employer or Retirement System for further information.

Retiree's SSN grid

Retiree's SSN

Applicant's SSN grid

Applicant's SSN

Application MUST be signed by retirement Insurance Coordinator.

Please mail application to the appropriate retirement system listed below:

KY Retirement System (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

Kentucky Community &
Technical College System
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-reference payment option.