Do Not Staple
Kentucky Employees' Health Plan
Department of Employee Insurance
KEHP.KY.GOV ● 1-888-581-8834

2015 KEHP
ACTIVE EMPLOYEE HEALTH INSURANCE ADD/DROP FORM

Section 1: ***To Be Completed by Insurance Coordinator/HR Generalist***					
Employee's SSN	/ /	Employee Personnel Number		Home County Code	
Company Name			Company Number		
Date of Hire	/ /	Coverage Effective Date	/ /	Org. Unit Number	
Reason for submission:	❑ Qualifying Event	❑ Other			

Section 2*: Demographic Information*

Name (Last, First, MI) _____ Date of Birth / /

Street Address _____ Home Phone Number _____ Cell Phone Number _____

City, State, ZIP _____ Home Email Address _____ Work Email Address _____

Gender ❑ Male ❑ Female
Married ❑ Yes ❑ No

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 ❑ No ❑

Section 3: *Change Information*

Please select one QE Reason _____ Date of Event: / /

	Adding Dependents		**Dropping Dependents**
	Marriage — **Copy of marriage certificate attached?** Yes ❑ No ❑		Divorce — **Copy of Divorce Decree attached?** Yes ❑ No ❑
	Birth/Adoption of Child — **Copy of birth certificate or placement documents attached?** Yes ❑ No ❑		Death — No documentation required.
	Loss of Other Coverage — **Letter from HR or Certificate of Prior Coverage attached?** Yes ❑ No ❑		Gaining Other Coverage — **Letter from HR or Certificate of Prior Coverage attached?** Yes ❑ No ❑
	Loss of KCHIP/Medicaid — **MET form attached?** Yes ❑ No ❑		Gaining Medicare/Medicaid — **MET form attached?** Yes ❑ No ❑
	Guardianship/Court Order — **Copy of Court Order attached?** Yes ❑ No ❑		Other Permitted (explain):

Section 4: *Plan Election*

	Benefit Option			**Coverage Level**
	LivingWell CDHP ⟶ I agree to the LivingWell promise	❑		Single (self only)
	LivingWell PPO ⟶ I agree to the LivingWell promise	❑		Parent Plus (self and child(ren))
	Standard PPO			Couple (self and spouse)
	Standard CDHP			Family (self, spouse, and child(ren))

Waive Health Insurance and Elect:		Waiver HRA		Waiver Dental/Vision ONLY HRA		NO HRA – not eligible

Plan Year 2015

Employee's Name

Section 5: ***Dependent Information***						
Spouse's Social Security Number	**Name** (Last, First, Middle Initial)		**Birth Date** MONTH/ DAY/ YEAR	**Gender**	**Cross-Reference Payment Option (LRP, JRP not eligible)** ❑ Yes (Employee, Spouse & child(ren))	
			/ /			
Note: If Cross Reference Payment Option Complete This Information on Spouse:						
Spouse's Organizational Unit #: **Spouse's** Company #:	❑ **Dual Employee**	❑ **Hazardous Duty**	**Date of hire/retirement** ___/___/___	**Has Spouse smoked in the last 6 months?** ❑ Yes ❑ No		
Child 1			___/___/___	❑Male ❑Female	❑Natural ❑Adopted ❑Court Ordered	❑Foster ❑Step ❑Disabled
Child 2			___/___/___	❑Male ❑Female	❑Natural ❑Adopted ❑Court Ordered	❑Foster ❑Step ❑Disabled
Child 3			___/___/___	❑Male ❑Female	❑Natural ❑Adopted ❑Court Ordered	❑Foster ❑Step ❑Disabled

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 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:

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, 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.
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.

Review the Authorization and Certification information below.

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 form 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 the first day of the following plan year. If I am a new employee electing a KEHP plan option outside of open enrollment, the plan will be effective in accordance with my employer's new hire waiting period rules (generally the first day of the second month after a new employee is eligible to enroll in the health plan).
- 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).
- KEHP uses third parties, including Anthem Blue Cross/Blue Shield and CVS/caremark, 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.
- 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.
- 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.
- The elections indicated by this form may not be changed or cancelled during the plan year without a permitted Qualifying Event.
- I authorize my employer to deduct from my earnings the amount required to cover my employee share of the premium contribution for the plan(s) I have selected, including any arrears I may owe. I authorize payment of my employee premium contributions to be made on a pre-tax basis unless I sign a Post-Tax Request Form.
- 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.

Plan Year 2015

Employee's Name

- If I elect to waive KEHP health insurance coverage, with or without a stand-alone Waiver Health Reimbursement Account (HRA), I am doing so voluntarily. There are two options under the HRA: Waiver HRA and the Waiver Dental/Vision ONLY HRA.
- KEHP provides plan options that, under the Affordable Care Act, constitute minimum essential coverage that is affordable and provides a minimum value. As such, by receiving an offer of coverage through my employer, I am not eligible for a health insurance premium tax credit if purchasing insurance through the health insurance exchange.
- The four KEHP plan options and the Waiver HRA must pay primary to Medicare, and the Waiver Dental/Vision ONLY HRA will be secondary to Medicare.
- A KEHP 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.
- My WageWorks® Healthcare Card will be suspended if the required HRA claim verification is not sent to WageWorks within sixty (60) 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 paycheck, 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 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.
- 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; and (2) keeping my contact information (i.e. mailing address, phone number, and email) current in KHRIS. If I am choosing a LivingWell plan option during open enrollment, I will complete the Health Assessment between January 1, 2015 – May 1, 2015. If I am a new employee and I choose a LivingWell plan option outside of open enrollment, I will complete the Health Assessment 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 form certifies that all information provided during this enrollment opportunity is correct to the best of my knowledge.

PLEASE SUBMIT THIS FORM TO YOUR COMPANY IC/HRG

Employee Signature	Date
Spouse Signature – *REQUIRED* if electing the cross-reference payment option	Date
IC/HRG Signature	Date
Spouse's IC/HRG Signature – *REQUIRED* if electing the cross-reference payment option	Date