



Plan Year 2027 RETIREE HEALTH INSURANCE ENROLLMENT/CHANGE FORM

Section 1: To Be Completed by Insurance Coordinator

KHRIS Personnel Number	Hazardous Duty ☐	Date of Retirement	Qualifying Event Date	Coverage Effective Date	
☐ KPPA 80000 10006416	☐ TRS 85000 10006418	☐ KCTCRS 81000 10006417	☐ JRP 86000 10006419	☐ LRP 87000 10006420	☐ KPPA RTW 80100 10006464
KPPA Only:	☐ KPPA-KERS	☐ CERS - Oth.Ag	☐ KPPA-SPRS		
Reason(s) for Application: ☐ Open Enrollment ☐ New Retiree ☐ Returning Retiree ☐ Applicant becomes the PH ☐ Qualifying Event ☐ Exception ☐ Demographic Change ☐ Termination		Qualifying Event: ☐ Marriage ☐ Birth/Adoption/Placement ☐ Court Order for Child ☐ Divorce ☐ Death - Date: _____ ☐ Loss of Individual Health ☐ Loss of Group Health ☐ Spouse turned 65			Termination: Coverage End Date
☐ Begin Medicare/Medicaid ☐ End Medicare/Medicaid ☐ Loss of KCHIP ☐ Spouse/Dependent Starting Employment ☐ Spouse/Dependent Terminating Employment ☐ Special Enrollment ☐ 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) If plan holder is not the Retiree	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: ☐ Male ☐ Female		Married: ☐ Yes ☐ No
***Required information for processing. Are you Medicare eligible due to Social Security disability? ☐ Yes ☐ No		

Race/Ethnicity Data: The Commonwealth of Kentucky does not discriminate on the basis of race, color, religion, sex, national origin, sexual orientation, gender identity or expression, ancestry, age, pregnancy or related medical condition, marital or familial status, disability, veteran status, political affiliation, or genetic information, in accordance with state and federal laws. **Completion of the questions below is OPTIONAL and will NOT affect the terms or conditions of your medical coverage or your eligibility for medical coverage.** The federal government strongly encourages employers and health plans to collect social data about individuals to better identify environmental and personal conditions that affect a wide range of health and quality-of-life outcomes. **This data will be kept private and used only to help the Commonwealth of Kentucky better understand how to provide healthcare services to you. Please select the one category with which you identify:**

- ☐ Hispanic or Latino ☐ White (Non-Hispanic or Latino) ☐ Asian (Non-Hispanic or Latino) ☐ Black or African American (Non-Hispanic or Latino)
☐ Native Hawaiian or Other Pacific Islander (Non-Hispanic or Latino) ☐ American Indian or Alaska Native (Non-Hispanic or Latino) ☐ Two or more races
☐ I choose not to answer

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

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

***Required information for processing: Are any dependents Medicare eligible due to Social Security disability? ☐ Yes ☐ No		If yes, who?				
Child #1 SSN	Name (Last, First, MI)	☐ Natural ☐ Adopted ☐ Court Ordered	☐ Foster ☐ Step ☐ Disabled	Date of Birth	☐ Male ☐ Female	☐ Add ☐ Drop ☐ Remain
Child #2 SSN	Name (Last, First, MI)	☐ Natural ☐ Adopted ☐ Court Ordered	☐ Foster ☐ Step ☐ Disabled	Date of Birth	☐ Male ☐ Female	☐ Add ☐ Drop ☐ Remain

Retiree's SSN: _____

Applicant's SSN: _____

Child #3 SSN	Name (Last, First, MI)	☐ Natural ☐ Adopted ☐ Court Ordered	☐ Foster ☐ Step ☐ Disabled	Date of Birth	☐ Male ☐ Female	☐ Add ☐ Drop ☐ Remain
Child #4 SSN	Name (Last, First, MI)	☐ Natural ☐ Adopted ☐ Court Ordered	☐ Foster ☐ Step ☐ Disabled	Date of Birth	☐ Male ☐ Female	☐ Add ☐ Drop ☐ Remain
Child #5 SSN	Name (Last, First, MI)	☐ Natural ☐ Adopted ☐ Court Ordered	☐ Foster ☐ Step ☐ Disabled	Date of Birth	☐ Male ☐ Female	☐ Add ☐ Drop ☐ Remain

Section 5: Tobacco Use Declaration Rules governing the Tobacco Use Declaration can be found in your Benefits Selection Guide or at kehpnky.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? ☐ Yes ☐ No	Has your spouse, if covered under this plan, used tobacco regularly within the past 6 months? ☐ Yes ☐ No	Have any children covered under this plan age 18 or older used tobacco regularly within the past 6 months? ☐ Yes ☐ No If yes, who? _____
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Section 6: Coverage Level

Note: If adding newly covered dependents you will be contacted later to provide dependent verification documents to our dependent eligibility audit vendor.

☐ Single (self only)	☐ Parent Plus (self and child(ren))	☐ Couple (self and spouse)	☐ 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 kehpnky.gov in the Benefits Selection Guide.

- ☐ LivingWell CDHP
☐ LivingWell PPO
☐ LivingWell Basic CDHP
☐ LivingWell High Deductible Health Plan
☐ Default LivingWell Basic CDHP (no HRA funds) - INSURANCE COORDINATOR USE ONLY
☐ Waive Coverage, No HRA - without \$ Reason for Waiving: _____

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