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***

Select 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 attached? ❑ Yes ❑ No	❑	Gaining Other Coverage	Letter from HR 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 Reason/Explain	

IF QE REQUIRES THE COMPLETION OF A NEW HEALTH INSURANCE ENROLLMENT APPLICATION, PLEASE SUBMIT WITH THIS ADD/DROP FORM
PLEASE REFER TO THE ADMINSTRATION MANUAL TO DETERMINE IF AN APPLICATION IS REQUIRED WITH THIS FORM

PLEASE SUBMIT THIS FORM TO YOUR COMPANY IC/HRG

Employee Signature _____ Date _____

IC/HRG Signature _____ Date _____