Do Not Staple

Kentucky Employees' Health Plan
Department of Employee Insurance
KEHP.KY.GOV ● 1-888-581-8834

2014 KEHP
UPDATE FORM

To be completed by Insurance Coordinator/HR Generalist only. DO NOT use this form to add or drop dependents.

This form is to be used to update information on health insurance, FSA and HRAs.

General Information (required)

Name:	**Personnel Number:**	**SSN:**
Organizational Unit:	**Company Number:**	**Company Name:**

Update Reason

❑ **Termination:** **Date Employment Ends** _____ **Date Health Insurance Terminates** _____

Reason: ❑ Resigned ❑ Retired ❑ LWOP ❑ Death ❑ Military Leave ❑ Other _____

❑ **Reinstate Coverage:** **Date Returned to Work** _____ **Date Insurance Effective** _____

Reason: ❑ Rehired ❑ FMLA ❑ LWOP ❑ Military Leave ❑ Other _____

❑ **Transfer or Summer Transfer**

- To be completed by the **NEW** company
- No changes to current coverage allowed

Prior Company Number _____	**New Company Number** _____
Last Day Worked at Prior Company _____	**Date Hired at New Company** _____
Coverage End Date at Prior Company _____	**Coverage Begin Date at New Company** _____

Is Member Cross Reference
❑ Yes ❑ No

Current Benefit Option
❑ LivingWell CDHP
❑ LivingWell PPO
❑ Standard PPO
❑ Standard CDHP

Current Coverage Level
❑ Single (self only)
❑ Parent Plus (self and child(ren)
❑ Couple (self and spouse)
❑ Family (self, spouse and child(ren)

Other Changes or Corrections

For: ❑ **Member** ❑ **Spouse** ❑ **Child(ren)**

Name	New:		
	Previous:		
New Address (where mail is received)	Street Address:		
	City:	State:	Zip Code:
E-Mail Address			
SSN	Correct:	Incorrect:	
Date of Birth	Correct:	Incorrect:	
Other			

I acknowledge and understand that DEI will comply with HIPAA rules and that disclosure of information will be done under the rules of such Federal law. I further authorize DEI to use such information and to disclose such information to third party administrators, vendors, consultants, governmental authorities with jurisdiction and other necessary parties when necessary for my care or treatment, payment for services, the operation of my health plan or to conduct related activities.

Employee Signature _____ Date _____

Insurance Coordinator/HRG Signature _____ Date _____

Insurance Coordinator/HRG: Mail this form to DEI, 501 High Street, 2nd Floor, Frankfort, KY 40601