



**STATE EMPLOYEE HEALTH PLAN (SEHP)
CHANGE FORM**
PLEASE PRINT CLEARLY AND COMPLETE ENTIRE FORM

**For
HR
Use
ONLY**

EMPLOYEE ID # _____
STATE AGENCY # _____
NON STATE GROUP # _____
EFFECTIVE DATE _____

EMPLOYEE INFORMATION – (EMPLOYEE MUST COMPLETE)

NAME (LAST, FIRST, MI)	SOCIAL SECURITY NUMBER	GENDER M F O O	Date of Birth (Mo/Day/Yr)	MAILING ADDRESS <input type="radio"/> Current Address <input type="radio"/> Change of Address	
				STREET ADDRESS	
				CITY, STATE ZIP	COUNTY

ENROLLMENT CHANGE – (EMPLOYER MUST COMPLETE)

IF ADDING DEPENDENTS:

1. Do you wish to add dependent medical?
 Yes No

2. Do you wish to add dependent dental?
 Yes No

3. Do you wish to add dependent vision?
 Yes No

EMPLOYER MUST COMPLETE:
(SEE BACK OF FORM FOR COVERAGE LEVEL CODES)

Medical/RX coverage level from: _____ to _____

*Dental coverage level from: _____ to _____

Vision coverage level from: _____ to _____

Date of event: ____ / ____ / ____

DIRECT BILL – *If Direct Bill Member elects to drop dental coverage, the member will not be allowed back into the Dental Plan.

Medical Carrier from: _____ to _____

TYPE OF EVENT (CHECK ONE)

1. Member waiving coverage

2. Name change from: _____ to: _____

3. Leave Without Pay: Continue in SEHP? Yes No

4. Return from Leave Without Pay

5. Cancellation due to Non-payment

6. Death of Employee: Dependent(s) continue in SEHP? Yes* No

7. Disability or Elected Official: Continue in SEHP? Yes* No

8. Retirement: Continue in SEHP? Yes* No
 Member and spouse enrolling in different plans due to Medicare eligibility *
 Drop State Rx Drop Dental
 Non-State Option: Subsidized Retiree Non State Benefit Program

*If eligible for MEDICARE bottom section must be completed

9. Change in Employee Status to Full-Time Part-Time Ineligible

10. Change in Payment Status to Before Tax due to: _____ []

Requests for the following changes must be completed within 31 days of date of event:

11. Marriage of employee 15. Marriage of dependent

12. Final divorce of employee 16. Death of spouse or dependent

13. Childbirth 17. Employee, Spouse or Dependent's gain or loss of employment and benefits

14. Adoption

18. Other (specify): _____

Additional Non State Group Events (not for University use)

19. Termination Voluntary Involuntary 20. Address change

DEPENDENT INFORMATION (List spouse and/or unmarried dependent children to be covered – subject to definition and Relationship codes on reverse)

Action Add Delete	Relationship Code (See back of form)	Name (Last, First, MI)	Social Security Number (Required)	Gender		Date of Birth Month / Day / Year
				M	F	
<input type="radio"/>	<input type="radio"/>			<input type="radio"/>	<input type="radio"/>	
<input type="radio"/>	<input type="radio"/>			<input type="radio"/>	<input type="radio"/>	
<input type="radio"/>	<input type="radio"/>			<input type="radio"/>	<input type="radio"/>	
<input type="radio"/>	<input type="radio"/>			<input type="radio"/>	<input type="radio"/>	

DEPENDENT ADDRESS: Same As Employee Different – PLEASE PROVIDE: _____

MEDICARE (If you, your spouse and or dependent is eligible for Medicare and are to be covered under the SEHP, please complete the following information and attach copies of all Medicare cards as they are REQUIRED.)

Name (Last, First, MI)	Hospital (Part A) (Mo/Day/Yr)	Medical (Part B) (Mo/Day/Yr)	Medicare Claim Number

EMPLOYEE AUTHORIZATION: By my signature below, I agree to the Terms and Conditions as listed on the reverse of this form. I also understand that I must provide supporting documentation regarding any change in family status along with this enrollment form in order for my form to be processed.

Signed: _____ Date: _____
EMPLOYEE SIGNATURE – DO NOT PRINT

PERSONNEL OFFICER AUTHORIZATION: By my signature below, I understand that incomplete forms and forms submitted without required supporting documentation will be returned to me and must be returned to KHPA within 31 days of the qualifying event.

Personnel Officer Printed Name: _____

Personnel Officer Signature: _____

Telephone Number (include ext.): _____ Date: _____

AUTHORIZATION: TERMS AND CONDITIONS

NON TOBACCO USER DISCOUNT

1. I AM A TOBACCO USER

- a. I agree to allow the State of Kansas Health Care Commission and/or Kansas Health Policy Authority to enroll me in a cessation program that I will complete, to their satisfaction, prior to the end of the 2010 plan year as a condition to obtaining the discount.

By making this election I affirmatively declare that I am a tobacco user. However, prior to the end of the 2010 plan year, I will complete the tobacco cessation program in which I shall be enrolled by the State of Kansas Health Care Commission and/or Kansas Health Policy Authority. As a direct result of my agreement to complete this cessation program, I will receive the non-tobacco user discount for the 2010 plan year.

- b. I will not enroll in or complete a cessation program and understand that I will not get the discount.

By making this election I affirmatively declare that I am a tobacco user and choose not to participate in the non-tobacco user discount for the 2010 plan year.

2. I AM NOT A TOBACCO USER

- a. By making this election I affirmatively declare that I will not use tobacco, in any form, during the 2010 plan year. I understand that even a single instance of tobacco use may constitute a fraudulent misrepresentation on my part and may subject me to penalties which may include, but may not be limited to, elimination of employer contribution to my health insurance premium.

3. I CHOOSE NOT TO DISCLOSE MY STATUS

- a. I choose not to disclose my status as it relates to tobacco use. I understand that by not making an election I am choosing not to participate in the non-tobacco user discount for the 2010 plan year. No negative inferences shall be made based on my decision not to disclose my status.

I acknowledge that if I do not make a Tobacco Use election and do not return this form, I will automatically be defaulted to the base rate and will not be able to participate in the non tobacco user discount for the 2010 plan year.

COVERAGE LEVEL CODES:

- 1 = Member Only
2 = Member and Spouse Only
3 = Member and Child(ren) Only
4 = Member and Family (Spouse AND Child(ren))

RELATIONSHIP CODES:

- SP = spouse
D = daughter
P = stepson or stepdaughter
S = son
GC = grandson or granddaughter
L = legal custody dependent
XX = qualified medical child support order
H = handicapped child over age 23

• I have read and agree to the provisions in both the "State of Kansas Open Enrollment Booklet" and the "State of Kansas Benefits Guidebook" for the plan year in which I am enrolling.

• I am responsible for reviewing my benefit selections and the deductions for coverage on the State of Kansas Employee Service Center and my payroll statement. If there is an error on my payroll statement, I must contact my personnel officer within 14 working days in order to make any corrections. If I fail to take this action timely, I waive my right to correct my election for the remainder of the current plan year.

• If enrolling in SEHP coverage, I authorize the deduction from my earnings for the cost of coverage which I have selected. I understand that payment on a pretax basis means that my gross pay will be reduced by the cost of the coverage before federal, state, FICA and Medicare taxes are deducted.

• I verify the information on the Enrollment Form to be complete and accurate to the best of my knowledge. I understand that my answers to the questions contained on this Enrollment Form will be used to determine eligibility for coverage. I further understand that if any material information is omitted or incorrect, it could provide the basis to refuse or rescind coverage and to refund any premiums paid as though coverage had never been in force.

• If waiving coverage in the SEHP at this time, I understand that enrollment at a later date is subject to late enrollment restrictions and may or may not be approved.

• I cannot start, change or stop any pretax election until the next open enrollment period unless I experience a qualifying event. **If I experience a qualifying event, I must complete an Enrollment or Change Form within 31 calendar days of the event causing the change. I must provide appropriate supporting documentation of the event. KHPA must receive the completed form and appropriate supporting documentation within 10 days of completion.**

• If enrolling my dependent(s) for coverage, I certify that they meet the requirements for dependent coverage. Any attempt by me to enroll dependents which do not meet the requirements will be considered fraud and will be subject to penalties as prescribed by law. **I must provide appropriate proof of dependency for each dependent such as marriage license or birth certificate, along with the Enrollment or Change Form.**

• Any open enrollment change made in anticipation of a qualifying event such as a pending divorce will not be allowed. If I am in the midst of divorce proceedings, my covered spouse cannot be dropped from coverage until the granting of the final divorce decree.

• I agree to the following terms for myself and my dependents: Unless otherwise prevented by law, we authorize health care providers, insurers, claims administrators and employers to provide medical, employment and benefit information, including information relating to drug, alcohol or psychiatric histories and treatment, to the insurance provider or its authorized representatives. Except as otherwise prevented by law, the insurance provider or its authorized representatives may share such information and provide it to the employer, other insurers, claims administrators, re-insurers and other provider organizations only for the purpose of administering the group coverage and claims for benefits, utilization review, risk management, provider peer review and the resolution of grievances relating to health benefit coverage and care. This authorization shall be valid for the duration of coverage.

• I acknowledge that I have obtained a copy of this authorization.

• I agree that a reproduced copy of this authorization will be as valid as the original.