



# STATE EMPLOYEE HEALTH PLAN HealthyKIDS PROGRAM APPLICATION

## Program Information

HealthyKIDS is a pilot program that helps eligible state employees with their premium for children's health insurance coverage in the State Employees Health Plan. State employee families eligible for HealthyKIDS will have 90% of the premium for their covered children paid by the state and be responsible for the remaining 10%.

State employees can apply for the HealthyKIDS program during Open Enrollment or when a qualifying event happens within the year. New employees to the State of Kansas may apply for HealthyKIDS during their individual enrollment window. If you have questions about the program or what constitutes a qualifying event, contact your agency Human Resource officer.

Applications may take up to 45 days to process. If you would like to check the status of yours, call (785) 431-7190 between the hours of 9:00 a.m. – 4:00 p.m.

Mail your completed application to:

Kansas Health Policy Authority  
State Employee Health Plan—HealthyKIDS  
Landon State Office Building  
900 SW Jackson St., Rm. 900-N  
Topeka, KS 66612-1251

## Things to Remember

To expedite the processing of your application, use this checklist to make certain you have everything that is needed.

- o Carefully read and answer all of the questions that apply to your situation on this application. If questions are left blank, your application will be denied.
- o Be sure to sign and date the application form. If the application is not signed, your application will be denied.
- o Whenever asked, use the state employee ID# which shows on your pay advice.

You may be required to submit information not requested on this application form; KHPA may verify any information provided by you; and that incomplete or erroneous information is just cause for rejection of your application and/or sufficient cause for discharge.

**Please mark one of the following:**

- [ ] Open Enrollment
- [ ] New Employee (Date of Hire) \_\_\_\_\_
- [ ] Other (specify) \_\_\_\_\_  
Date of Event \_\_\_\_\_

**State Employee Data:** If more than one family member is employed with the state, please designate only one as the applicant. If we need additional information, we will try to contact you by phone. Which time is the best to reach you? AM or PM (circle one) Is it ok to call you at work? Yes or No (circle one)

Name \_\_\_\_\_ State Employee ID# \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home# \_\_\_\_\_ Work# \_\_\_\_\_ Message# \_\_\_\_\_

**Family Information:** Please list everyone in your household starting with the state employee applicant on the first line. Attach another page, if more room is needed.

FULL NAME	SOCIAL SECURITY NUMBER	RELATIONSHIP TO STATE EMPLOYEE APPLICANT	DATE OF BIRTH	SEX	FULL NAME OF PARENTS (ONLY FOR CHILDREN UNDER AGE 19)	
					FATHER	MOTHER
		EMPLOYEE				

**Income Information:** If anyone in the household receives income, including but not limited to the following sources, complete the chart below. Use the first line for the state employee applicant. All income must be reported. If anyone is self-employed, list the average monthly income from self-employment after expenses.

- \* employment/tips      \* child support      \* worker's compensation      \* military allotments      \* rental income      \* alimony      \* pensions
- \* unemployment      \* Social Security/SSI      \* monthly income from family      \* veteran's benefits      \* other (investment income, interest, etc.)

NAME OF PERSON WORKING OR RECEIVING INCOME	TYPE OF INCOME	EMPLOYER NAME & TELEPHONE NUMBER IF APPLICABLE	AMOUNT BEFORE-TAXES/ DE-DUCTIONS	AMOUNT OF TIPS / COM-MISSION	HRLY WAGE / HRS WRKD PER WEEK	PAID—(WKLY, EVERY 2 WEEKS, TWICE A MONTH, OR MONTHLY)	DAYS OF WK/ MONTH PAID	NEXT PAY-DATE
	WAGES	STATE OF KANSAS				Bi-Weekly	Friday	

**Incomplete applications will not be processed and will be returned to be completed. This could cause a denial of the application or a possible overpayment of premiums if approved.**

**Signature and Authorization to Release Information:** My signature on this application signifies that my answers are correct and complete to the best of my knowledge. I understand my signature authorizes employers and other persons or agencies with knowledge of my circumstances to release information to the Kansas Health Policy Authority (KHPA) which is necessary to establish my eligibility. My signature on this application form also authorizes the use and disclosure of my family's personal information within KHPA. This authorization is valid from this date. A copy of this authorization is as valid as the original. This application must be signed and dated in order to be considered complete. All information provided on this application is protected by state and federal confidentiality laws. The State Employees Health Plan determines who ultimately receives the increased employer contribution through HealthyKIDS.

Signature of State Employee Applicant: \_\_\_\_\_ Date: \_\_\_\_\_