



STATE EMPLOYEE HEALTH PLAN (SEHP)
ENROLLMENT 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) - (EMPLOYEES AND SPOUSES AGE 65 AND OVER MUST ALSO COMPLETE HEALTH CARE SELECTION FORM).

NAME (LAST, FIRST, MI)

SOCIAL SECURITY NUMBER

GENDER M F O O

Date of Birth (Mo/Day/Yr)

MAILING ADDRESS O Current Address O Change of Address

STREET ADDRESS

CITY, STATE ZIP

COUNTY

EMPLOYEE INFORMATION - (EMPLOYER MUST COMPLETE)

Date currently employed in eligible position

Date employed in non-eligible position (if applicable)

NON STATE/REGENTS BENEFIT PROGRAM GROUP

Must check only one

O P1 O F1 O F2 O F3

TYPE OF ACTION - (EMPLOYER MUST COMPLETE)

O Open Enrollment
O New Address (See Above)

O New Employee

O Other (specify)

Date of Event

____/____/____

COVERAGE ELECTION - (EMPLOYEE MUST COMPLETE)

GENERAL INFORMATION (CHECK ONE)

How do you wish to pay for the cost of coverage?
O Before Tax O After-tax

TOBACCO USE - Do you use any form of tobacco? Please see Non Tobacco use information on back of this form.

O Yes* O No O Choose not to disclose

*If you answered yes, are you willing to enroll in the HealthQuest tobacco cessation program? O Yes O No

MEDICAL INSURANCE PROVIDER - (CHECK ONE)

Blue Cross and Blue Shield

O Plan A
O Plan B

Coventry Health Care of Kansas

O Plan A
O Plan B
O Plan C -attach HSA Form

Preferred Health Systems

O Plan A
O Plan B
O Plan C -attach HSA Form

UMR-A UnitedHealthCare Company

O Plan A
O Plan B
O Plan C -attach HSA Form

MEDICAL AND PRESCRIPTION DRUG COVERAGE LEVEL (CHECK ONE)

O Waive Coverage
O 1 Member only O 3 Member and Child(ren)
O 2 Member and Spouse O 4 Member and Family

DENTAL COVERAGE LEVEL (CHECK ONE) - (4 - DEPENDENT DENTAL IS AVAILABLE ONLY IF DEPENDENT MEDICAL COVERAGE IS SELECTED - AND WILL BE AT THE SAME LEVEL AS MEDICAL)

O 1 Member only O 4 Dependent Dental

VISION COVERAGE PLAN (CHECK ONE)

O Basic Plan O Enhanced Plan O Waive Vision Coverage

VISION COVERAGE LEVEL (CHECK ONE)

O 1 Member only O 3 Member and Child(ren)
O 2 Member and Spouse O 4 Member and Family

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

Table with 5 columns: Relationship Code, Name (Last, First, MI), Social Security Number (Required), Gender (M/F), Date of Birth (Month/Day/Year). Includes 4 empty rows for dependent information.

DEPENDENT ADDRESS: O Same As Employee O 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.)

Table with 4 columns: Name (Last, First, MI), Hospital (Part A) (Mo/Day/Yr), Medical (Part B) (Mo/Day/Yr), Medicare Claim Number. Includes 2 empty rows.

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.