

**KANSAS STATE EMPLOYEE HEALTH CARE COMMISSION
EMPLOYEE ADVISORY COMMITTEE**

State Retiree/Direct Bill Nominee Information Form

Name: _____

Home Address: _____

E-Mail Address: _____

Phone: _____

State Agency from which you retired: _____

Position held: _____

Gender (Check one): _____ **Female** _____ **Male**

Are you Medicare eligible: _____ **Yes** _____ **No**

Health Plan enrolled in: _____

Who is Covered by the SEHP?

Only Myself _____

My Spouse & I _____

My Child(ren) & I _____

My Spouse & Child(ren) & I _____

Why are you interested in serving as a member on the Employee Advisory Committee?

RETURN TO: State Employee Health Plan, ATTN: Jennifer Flory
900 SW Jackson, Room 900-N
Topeka, Kansas 66612-1251

**FAX: 785-368-7180
Email: Benefits@khp.ks.gov**