

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

Name: _____

State Agency: _____

Position: _____

State Agency Address: _____

Email Address: _____

County of Residence: _____

County of Work: _____

Work Phone: _____

Fax: _____

Salary Tier: (Check One) _____ **Length of State Service** _____

____ Tier 1 - less than \$28,000

____ Tier 2 - at least \$28,000 but less than \$48,000

____ Tier 3 - over \$48,000

Gender (Check One): _____ Male _____ Female

Age (Circle One): 20-30 31-40 41-50 51-64 65 or older

Health Plan: _____

Coverage Level:

Employee Only _____

Employee & Spouse Only _____

Employee & Child(ren) Only _____

Employee w/Spouse & Child(ren) _____

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

Return to:

State Employee Plan, Attn: Jennifer Flory

900 SW Jackson, Rm 900 N

Topeka, KS 66612-1251

Email: Benefits@khpas.gov

Fax: 785.368.7180