

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 under your 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:

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