Kansas
Department of Health and Environment
Division of Health Care Finance

STATE EMPLOYEE HEALTH PLAN (SEHP)
Health Plan Communication Form

This form may be used to communicate concerns, suggestions or requests concerning the SEHP. Please send the completed form to:

State Employee Health Plan
Membership Services
900 SW Jackson, Room 900
Topeka, KS 66612-1220

Member Information			
Name	**Employee ID**	**Social Security Number**	
Address (City, State and Zip Code)	**Are your benefits paid before or after tax?** Pretax ☐ After Tax ☐	**Work Telephone** (Include Area Code)	**Work Email**
Agency Name	**Agency Number**	**Health Plan Provider**	
Member's Signature		**Date this form was signed**	

Please write your concern below:

Agency / Human Resource Officer's Name	**Agency / Human Resource Officer's Phone Number**

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