Kansas Department of Health and Environment
Division of Health Care Finance

STATE EMPLOYEE HEALTH PLAN (SEHP)
DIRECT BILL GROUP HEALTH INSURANCE ENROLLMENT AND CHANGE FORM

PLEASE PRINT CLEARLY AND COMPLETE ENTIRE FORM

EFFECTIVE DATE	
SOCIAL SECURITY #	
MEMBER ID #	

NAME (LAST, FIRST, MI)			MAILING ADDRESS	
HOME TELEPHONE	DATE OF BIRTH MONTH/DAY/YEAR	GENDER ❑Male ❑Female	CITY, STATE ZIP	COUNTY
			EMAIL ADDRESS (ABOVE THIS LINE)	

TYPE OF ACTION - PLEASE NOTE THE ASTERISKS BELOW

❑ Add spouse and/or child(ren)	❑ Termination	❑ Enroll in Vision coverage ONLY *	❑ Drop state drug coverage
❑ Drop spouse and/or child(ren)	❑ Changing Carrier	❑ Drop dependent dental coverage	❑ Opt out of dental coverage **
❑ Split Enrollment	❑ Medicare eligible	❑ Enroll surviving spouse/dependent	

HEALTH PLAN ELECTION (PLEASE SELECT YOUR HEALTH PLAN BY CHECKING THE BOX BESIDE YOUR CHOICE)

2013 MEDICARE PLANS	2013 MEDICAL HEALTH PLANS	
❑ Coventry Advantra Freedom PPO with Coventry Part D	Blue Cross & Blue Shield:	❑ Plan A ❑ Plan B ❑ High Deductible Plan C
❑ Coventry Advantra Freedom PPO with SilverScript		
❑ Kansas Senior Plan C with SilverScript	Coventry/PHS:	❑ Plan A ❑ Plan B ❑ High Deductible Plan C
❑ Kansas Senior Plan C WITHOUT SilverScript		
	United Healthcare:	❑ Plan A ❑ Plan B ❑ High Deductible Plan C

MEDICAL, PRESCRIPTION DRUG, DENTAL AND VISION COVERAGE LEVEL (CHECK ONE BOX EACH)

COVERAGE LEVEL	MEDICAL	DRUG (OPTIONAL)	DENTAL** (OPTIONAL)	VISION (Optional) BASIC	VISION (Optional) ENHANCED
1. Member Only	❑	❑	❑	❑	❑
2. Member and Spouse	❑	❑	❑	❑	❑
3. Member and Child(ren)	❑	❑	❑	❑	❑
4. Member, Spouse and Child(ren)	❑	❑	❑	❑	❑
B. Medicare Member Only	❑	❑	❑	❑	❑
WAIVE *	❑	❑	❑	❑	❑

*MEDICAL, DRUG AND DENTAL COVERAGE WILL BE TERMINATED AND YOU CANNOT RE-ENROLL AT A LATER DATE

**ONCE YOU OPT OUT OF DENTAL COVERAGE, YOU CANNOT RE-ENROLL IN DENTAL COVERAGE AT A LATER DATE

DEPENDENT INFORMATION (LIST SPOUSE AND/OR DEPENDENT CHILDREN TO BE COVERED – SUBJECT TO DEFINITION AND RELATIONSHIP CODES ON REVERSE)

PLEASE NOTE: IF ADDING DEPENDENTS TO COVERAGE, PLEASE PROVIDE ACCEPTABLE DOCUMENTATION SUCH AS MARRIAGE LICENSE OR BIRTH CERTIFICATE

Add	Remove	Relationship Code	Name (Last, First, MI)	Social Security Number (REQUIRED)	Gender M	Gender F	Date of Birth MONTH / DAY / YEAR
❑	❑				❑	❑	
❑	❑				❑	❑	
❑	❑				❑	❑	

MEDICARE (IF YOU ARE ENROLLED IN MEDICARE AND WANT TO ELECT SEHP COVERAGE, PLEASE COMPLETE THE FOLLOWING INFORMATION AND ATTACH A COPY OF YOUR MEDICARE CARD AS IT IS REQUIRED.)

NAME (LAST, FIRST, MI)	HOSPITAL (PART A) (MO/DAY/YR)	MEDICAL (PART B) (MO/DAY/YR)	MEDICARE CLAIM NUMBER

MEMBER 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: _____

MEMBER SIGNATURE – DO NOT PRINT

RETURN THIS FORM, ALONG WITH ANY SUPPORTING DOCUMENTATION TO:
KDHE Division of Health Care Finance – State Employee Health Plan – Direct Bill Membership Services
Rm. 900-N, Landon State Office Building, 900 SW Jackson Street, Topeka, Kansas 66612

AUTHORIZATION: TERMS AND CONDITIONS

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)]
B = Medicare Member Only

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 = totally disabled child over age 26

- I have read and agree to the provisions in the "**State of Kansas Direct Bill Open Enrollment Booklet**" for the plan year in which I am enrolling.

- I am responsible for reviewing my benefit selections for coverage on my confirmation statement. If there is an error on my confirmation statement, I must contact the SEHP Direct Bill Membership Services Department 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.

- 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 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. I understand they will not be added to my coverage unless the documentation is accepted by the SEHP.**

- 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, wellness and disease management, 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.