



**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 <input type="checkbox"/> Male <input type="checkbox"/> Female
			CITY, STATE ZI P		COUNTY
EMAIL ADDRESS (ABOVE THIS LINE)					

TYPE OF ACTION - PLEASE NOTE THE ASTERISKS BELOW

<input type="checkbox"/> Add spouse and/or child(ren)	<input type="checkbox"/> Termination	<input type="checkbox"/> Enroll in Vision coverage ONLY *	<input type="checkbox"/> Drop state drug coverage
<input type="checkbox"/> Drop spouse and/or child(ren)	<input type="checkbox"/> Changing Carrier	<input type="checkbox"/> Drop dependent dental coverage	<input type="checkbox"/> Opt out of dental coverage **
<input type="checkbox"/> Split Enrollment	<input type="checkbox"/> Medicare eligible	<input type="checkbox"/> Enroll surviving spouse/dependent	

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

2012 MEDICARE PLANS	2012 MEDICAL HEALTH PLANS
<input type="checkbox"/> Coventry Advantra Freedom PPO with Coventry Part D	<input type="checkbox"/> Blue Cross & Blue Shield Plan A
<input type="checkbox"/> Coventry Advantra Freedom PPO with SilverScript	<input type="checkbox"/> Blue Cross & Blue Shield Plan B
<input type="checkbox"/> Humana PPO with Humana Part D	<input type="checkbox"/> Coventry/PHS Plan A
<input type="checkbox"/> Humana PPO with SilverScript	<input type="checkbox"/> Coventry/PHS Plan B
<input type="checkbox"/> Kansas Senior Plan C with SilverScript	<input type="checkbox"/> UnitedHealthCare Plan A
<input type="checkbox"/> Kansas Senior Plan C WITHOUT SilverScript	<input type="checkbox"/> UnitedHealthCare Plan B

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

COVERAGE LEVEL	MEDICAL	DRUG (OPTIONAL)	DENTAL ** (OPTIONAL)	VISION (Optional)		*MEDICAL, DRUG AND DENTAL COVERAGE WILL BE TERMED AND YOU CANNOT RE-ENROLL AT A LATER DATE
				BASIC	ENHANCED	
1. Member Only	<input type="checkbox"/>	**ONCE YOU OPT OUT OF DENTAL COVERAGE, YOU CANNOT RE-ENROLL IN DENTAL COVERAGE AT A LATER DATE				
2. Member and Spouse	<input type="checkbox"/>					
3. Member and Child(ren)	<input type="checkbox"/>					
4. Member, Spouse and Child(ren)	<input type="checkbox"/>					
B. Medicare Member Only	<input type="checkbox"/>					
WAIVE *	<input type="checkbox"/>					

DEPENDENT INFORMATION (LIST SPOUSE AND/OR DEPENDENT CHILDREN TO BE COVERED - SUBJECT TO DEFINITION AND RELATIONSHIP CODES ON REVERSE)
PLEASE NOTE: IF YOU ARE ADDING DEPENDENTS TO YOUR COVERAGE, PLEASE PROVIDE DOCUMENTATION SUCH AS MARRIAGE LICENSE OR BIRTH CERTIFICATE

Add	Remove	Relationship Code	Name (Last, First, MI)	Social Security Number (REQUIRED)	Gender M F	Date of Birth MONTH / DAY / YEAR
<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> <input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> <input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> <input type="checkbox"/>	

MEDICARE (IF YOU ARE ELIGIBLE FOR MEDICARE AND ARE TO BE COVERED UNDER THE SEHP, 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 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 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 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.