



## AUTHORIZATION: TERMS AND CONDITIONS

- I have read and agree to the provisions in both the "State of Kansas Open Enrollment Booklet" and the "State of Kansas Benefits Guidebook" for the plan year in which I am enrolling.
- I am responsible for reviewing my benefit selections and the deductions for coverage on the State of Kansas Employee Service Center and my payroll statement. If there is an error on my payroll statement, I must contact my personnel officer 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.
- If enrolling in SEHP coverage, I authorize the deduction from my earnings for the cost of coverage which I have selected. I understand that payment on a pretax basis means that my gross pay will be reduced by the cost of the coverage before federal, state, FICA and Medicare taxes are deducted.
- 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 waiving coverage in the SEHP at this time, I understand that enrollment at a later date is subject to late enrollment restrictions and may or may not be approved.
- I cannot start, change or stop any pretax election until the next open enrollment period unless I experience a qualifying event. **If I experience a qualifying event, I must complete an enrollment or Change Form within 31 calendar days of the event causing the change. I must provide appropriate supporting documentation of the event. SEHP must receive the completed form and appropriate supporting documentation within 10 days of completion.**
- 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.**
- Any open enrollment change made in anticipation of a qualifying event such as a pending divorce **will not be allowed.** If I am in the midst of divorce proceedings, my covered spouse cannot be dropped from coverage until the granting of the final divorce decree.
- 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.

### AVAILABLE 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))

### 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