



STATE EMPLOYEE HEALTH PLAN (SEHP)
ENROLLMENT FORM
PLEASE PRINT CLEARLY AND COMPLETE ENTIRE FORM

For HR Use ONLY

Form fields for EFFECTIVE DATE, EMPLOYEE ID #, STATE AGENCY #, and NON STATE GROUP #.

EMPLOYEE INFORMATION (EMPLOYEE MUST COMPLETE) - (EMPLOYEES AND SPOUSES AGE 65 AND OVER MUST ALSO COMPLETE THE HEALTH CARE SELECTION FORM).

Form fields for NAME (LAST, FIRST, MI), STREET ADDRESS, CONTACT TELEPHONE, SOCIAL SECURITY NUMBER, GENDER, DATE OF BIRTH, CITY, STATE, ZIP, COUNTY, and EMAIL ADDRESS.

TOBACCO USE - (SEE NON TOBACCO USE INFORMATION ON BACK OF FORM) - IF NO DISCLOSURE IS MADE, THE DEFAULT IS THE BASE RATE - NO DISCOUNT

Form fields for TOBACCO USE: DO YOU USE ANY FORM OF TOBACCO? and *IF YOU ANSWERED YES, ARE YOU WILLING TO ENROLL IN THE HEALTHQUEST TOBACCO CESSATION PROGRAM?

TYPE OF ACTION - (EMPLOYER MUST COMPLETE) DATE OF HIRE/ EVENT: / /

Form fields for TYPE OF ACTION: OPEN ENROLLMENT, NEW ADDRESS, NEW EMPLOYEE, OTHER (SPECIFY HERE).

Form fields for EMPLOYEE INFORMATION - (EMPLOYER MUST COMPLETE): Employed in eligible position, Employed in NON-eligible position, and NON STATE/REGENTS SALARY TIER.

Form fields for COVERAGE ELECTION - (EMPLOYEE MUST COMPLETE): HOW DO YOU WISH TO PAY FOR THE COST OF COVERAGE? and Are you currently enrolled as a dependent in the State Employee Health Plan?

MEDICAL INSURANCE PROVIDER - (CHECK ONE)

Form fields for MEDICAL INSURANCE PROVIDER: Blue Cross and Blue Shield, Coventry/ Preferred Health Systems (PHS), and United HealthCare.

Form fields for MEDICAL AND PRESCRIPTION DRUG COVERAGE LEVEL (CHECK ONE) and DENTAL COVERAGE LEVEL (CHECK ONE).

Form fields for VISION COVERAGE PLAN (CHECK ONE) and VISION COVERAGE LEVEL (CHECK ONE).

DEPENDENT INFORMATION (LIST SPOUSE AND/OR DEPENDENT CHILDREN TO BE COVERED - SEE REVERSE FOR DEFINITIONS - DOCUMENTATION REQUIRED IF ADDING DEPENDENTS)

Table with 5 columns: RELATIONSHIP CODE, NAME (LAST, FIRST, MI), SOCIAL SECURITY NUMBER, GENDER, DATE OF BIRTH.

DEPENDENT ADDRESS: SAME AS EMPLOYEE or DIFFERENT - PLEASE PROVIDE:

MEDICARE (IF YOU OR YOUR DEPENDENTS ARE ELIGIBLE FOR MEDICARE AND ARE TO BE COVERED UNDER THE SEHP, PLEASE COMPLETE THE FOLLOWING INFORMATION AND ATTACH COPIES OF ALL MEDICARE CARDS AS THEY ARE REQUIRED.)

Form fields for MEDICARE: NAME (LAST, FIRST, MI), HOSPITAL (PART A), MEDICAL (PART B), and MEDICARE CLAIM NUMBER.

EMPLOYEE AUTHORIZATION: By my signature below, I agree to the Terms and Conditions as listed on the reverse of this form.

SIGNED: EMPLOYEE SIGNATURE - DO NOT PRINT DATE:

PERSONNEL OFFICER AUTHORIZATION: By my signature below, I understand that incomplete forms and forms submitted without required supporting documentation will be returned to me and must be returned to SEHP within 31 days of the qualifying event and within 10 days of the employee signature.

PERSONNEL OFFICER PRINTED NAME, PERSONNEL OFFICER SIGNATURE, TELEPHONE # (INCLUDE EXT.), DATE:

AUTHORIZATION: TERMS AND CONDITIONS

NON TOBACCO USE DISCOUNT

1. I AM A TOBACCO USER

- a. I agree to allow the State of Kansas Health Care Commission and/or the State Employee Health Plan to enroll me in the HealthQuest Program and complete the 5 tobacco discussions to their satisfaction by midnight July 31st of the plan year as a condition to obtaining the discount.

By making this election I affirmatively declare that I am a tobacco user. However, by midnight July 31st of the plan year, I will complete the 5 tobacco discussions to the satisfaction of the State of Kansas Health Care Commission and/or the State Employee Health Plan. As a direct result of my completion of these 5 tobacco discussions, I will receive the non-tobacco use discount for the plan year.

- b. I will **not** enroll in or complete 5 tobacco discussions through the HealthQuest Program and I understand that I will **not** get the discount.

By making this election I affirmatively declare that I am a tobacco user and choose not to participate in the non-tobacco use discount for the plan year.

2. I AM NOT A TOBACCO USER

- a. By making this election I affirmatively declare that I will not use tobacco, in any form, during the plan year. I understand that even a single instance of tobacco use may constitute a fraudulent misrepresentation on my part and may subject me to penalties which may include, but may not be limited to, elimination of employer contribution to my health insurance premium.

3. I CHOOSE NOT TO DISCLOSE MY STATUS

- a. I choose not to disclose my status as it relates to tobacco use. I understand that by not making an election I am choosing not to participate in the non-tobacco use discount for the plan year. No negative inferences shall be made based on my decision not to disclose my status.

I acknowledge that if I do not make a Tobacco Use election and do not return this form, I will automatically be defaulted to the base rate and will not be able to participate in the non tobacco use discount for the plan year.

COVERAGE LEVELS:

Member Only
Member and Spouse Only
Member and Child(ren) Only
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

• 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.**

• 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 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.