Kansas Department of Health and Environment
Division of Health Care Finance

STATE EMPLOYEE HEALTH PLAN (SEHP)
Health Plan Communication Form

Appendix F

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**