



STATE EMPLOYEE HEALTH PLAN (SEHP) CHANGE FORM

PLEASE PRINT CLEARLY AND COMPLETE ENTIRE FORM

FOR HR USE ONLY

Table with 2 columns: Field Name, Value. Fields include EFFECTIVE DATE, EMPLOYEE ID #, STATE AGENCY #, NSE GROUP #.

EMPLOYEE INFORMATION (EMPLOYEE MUST COMPLETE)

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

ENROLLMENT CHANGE (EMPLOYER MUST COMPLETE)

Form fields for Enrollment Change: CHANGE IN COVERAGE LEVEL, MEDICAL/RX FROM, *DENTAL FROM, VISION FROM, DATE OF EVENT.

*DIRECT BILL form: If a Direct Bill member elects to drop dental coverage, the member will not be allowed to re-enroll in the State Employee Health Plan Dental coverage.

ADDING DEPENDENTS: (EMPLOYEE MUST COMPLETE) 1. Do you wish to add dependent medical? 2. Do you wish to add dependent dental? 3. Do you wish to add dependent vision?

TYPE OF EVENT (EMPLOYER MUST COMPLETE)

Form fields for Type of Event: 1. MEMBER WAIVING COVERAGE, 2. NAME CHANGE FROM: TO:, 3. LEAVE WITHOUT PAY - CONTINUE COVERAGE?, 4. RETURN FROM LEAVE WITHOUT PAY, 5. CANCELLATION DUE TO NON-PAYMENT, 6. DEATH OF EMPLOYEE - DEPENDENTS CONTINUE COVERAGE?, 7. DISABILITY OR ELECTED OFFICIAL - CONTINUE COVERAGE?, 8. RETIREMENT - CONTINUE COVERAGE?, 9. EMPLOYEE STATUS CHANGE TO, 10. PAYMENT STATUS CHANGE TO BEFORE TAX DUE TO: REQUESTS FOR THE FOLLOWING CHANGES MUST BE COMPLETED WITHIN 31 DAYS OF THE DATE OF THE EVENT: 11. MARRIAGE OF EMPLOYEE, 12. FINAL DIVORCE OF EMPLOYEE, 13. CHILDBIRTH, 14. ADOPTION, 15. REMOVAL OF GRANDCHILD, 16. DEATH OF SPOUSE OR DEPENDENT, 17. EMPLOYEE, SPOUSE OR DEPENDENT'S GAIN OR LOSS OF EMPLOYMENT AND BENEFITS, 18. OTHER (SPECIFY):, 19. TERMINATION, 20. ADDRESS CHANGE.

DEPENDENT INFORMATION

Table for Dependent Information with columns: ACTION (ADD, DELETE), RELATIONSHIP CODE, NAME (LAST, FIRST, MI), SOCIAL SECURITY NUMBER (REQUIRED), GENDER (M, F), DATE OF BIRTH (MONTH / DAY / YEAR).

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

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.)

Table for Medicare information with columns: NAME (LAST, FIRST, MI), HOSPITAL (PART A) (MO/DAY/YR), MEDICAL (PART B) (MO/DAY/YR), MEDICARE CLAIM NUMBER.

EMPLOYEE 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: EMPLOYEE SIGNATURE - DO NOT PRINT

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

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