



**STATE EMPLOYEE HEALTH PLAN (SEHP)
CHANGE FORM**

**For HR
Use
ONLY**

EFFECTIVE DATE	
EMPLOYEE ID #	
STATE AGENCY #	
NON STATE GROUP #	

PLEASE PRINT CLEARLY AND COMPLETE ENTIRE FORM

EMPLOYEE INFORMATION (EMPLOYEE MUST COMPLETE)

NAME (LAST, FIRST, MI)				STREET ADDRESS	
CONTACT TELEPHONE	SOCIAL SECURITY NUMBER	GENDER M <input type="checkbox"/> F <input type="checkbox"/>	DATE OF BIRTH (Mo/Day/Yr)	CITY, STATE ZIP	COUNTY
EMAIL ADDRESS					

ENROLLMENT CHANGE (EMPLOYEE MUST COMPLETE)

CHANGE IN COVERAGE LEVEL
(EMPLOYER MUST COMPLETE)
(LEVEL CODES ARE LISTED ON THE BACK OF THIS FORM)

MEDICAL/RX FROM: _____ TO _____

*DENTAL FROM: _____ TO _____

VISION FROM: _____ TO _____

DATE OF EVENT: ____ / ____ / ____

***DIRECT BILL**
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

MEDICAL CARRIER FROM: _____
TO _____

ADDING DEPENDENTS:

1. DO YOU WISH TO ADD DEPENDENT MEDICAL?
 YES NO

2. DO YOU WISH TO ADD DEPENDENT DENTAL?
 YES NO

3. DO YOU WISH TO ADD DEPENDENT VISION?
 YES NO

TYPE OF EVENT

1. MEMBER WAIVING COVERAGE

2. NAME CHANGE FROM: _____ TO: _____

3. LEAVE WITHOUT PAY – CONTINUE COVERAGE? YES NO

4. RETURN FROM LEAVE WITHOUT PAY

5. CANCELLATION DUE TO NON-PAYMENT

6. DEATH OF EMPLOYEE – DEPENDENTS CONTINUE COVERAGE? YES NO

7. DISABILITY OR ELECTED OFFICIAL – CONTINUE COVERAGE? YES NO

8. RETIREMENT – CONTINUE COVERAGE? YES NO

MEMBER AND SPOUSE ENROLLING IN DIFFERENT PLANS DUE TO MEDICARE ELIGIBILITY? *YES NO

*IF ELIGIBLE FOR MEDICARE, COMPLETE BOTTOM SECTION

DROP STATE RX DROP DENTAL

SUBSIDIZED RETIREE – NON STATE ONLY OPTION

9. EMPLOYEE STATUS CHANGE TO FULL-TIME PART-TIME INELIGIBLE NON STATE BENEFIT PROGRAM

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 15. MARRIAGE OF DEPENDENT

12. FINAL DIVORCE OF EMPLOYEE 16. DEATH OF SPOUSE OR DEPENDENT

13. CHILDBIRTH 17. EMPLOYEE, SPOUSE OR DEPENDENT'S GAIN OR LOSS OF EMPLOYMENT AND BENEFITS
IS THIS GAIN OR LOSS OF COVERAGE WITH THE SEHP? YES NO

14. ADOPTION 18. OTHER (SPECIFY): _____

ADDITIONAL NON STATE GROUP EVENTS – NOT FOR UNIVERSITY USE

19. TERMINATION 20. ADDRESS CHANGE

VOLUNTARY INVOLUNTARY

DEPENDENT INFORMATION (List spouse and/or dependent children to be covered – see reverse for definitions – Documentation required if adding dependents)

ACTION ADD DELETE	RELATIONSHIP CODE (SEE BACK OF FORM)	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"/>	
<input type="checkbox"/> <input type="checkbox"/>				<input type="checkbox"/> <input type="checkbox"/>	

DEPENDENT ADDRESS: SAME AS EMPLOYEE DIFFERENT – PLEASE PROVIDE:

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

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

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 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

• 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.