Commonwealth of Kentucky
Personnel Cabinet
Department of Employee Insurance
Enrollment Information Branch
(502)564-1205

2011 DEPENDENT ADD FORM

Give this form to your Insurance Coordinator

This form must be used for any qualifying event (QE) that allows you to add dependents to your plan. *Complete an Enrollment Application for election changes such as option changes, new coverage, and new waiver or to begin a cross-reference plan.*

Applicant's SSN ___ - __ - ____ **Cross Ref Y/N** ☐ **Company Number** _____

Print Name (First,MI,Last)_____

The QEs listed on this form are the only events that allow you to ADD dependents to your plan. To be considered an eligible dependent, your dependent MUST meet the eligibility requirements as set forth in by KEHP.

You must also provide the required supporting documents for the Qualifying Event and the documentation to verify the eligibility of the dependent for coverage on this plan.

See your Insurance Coordinator for a list of Qualifying Event documentation and the dependent eligibility documents. **QE SUPPORTING DOCUMENTION AND VERIFICATION DOCUMENTS MUST BE SUBMITTED WITH THIS FORM**

NOTE: The requested change may be made effective on the day of the event or after it has already occurred. Generally, the effective date will be the 1st day of the month after the date you, the employee, signed the ADD Form. Ex: Event on 6/17, ADD Form signed 6/20, change approved effective 7/1.

Exceptions are Birth, Birth plus, Adoption, Placement and Placement for Adoption plus, which are effective on the date of the event; and National Medical Support Notices which are effective on the 1st day of the month after notice date.

Qualifying Events: (Check one) Must be signed within designated time period of the event date.

- ☐ Birth newborn only* (60 days)
- ☐ Birth plus other dependents* (35 days)
- ☐ Adoption*/ Placement for Adoption* (60 days)
- ☐ Adoption*/ Placement for Adoption* plus other dependents *(35 days)
- ☐ Legal guardianship*, Administrative Order* or court order* pertaining to health insurance+ (35 days)
- ☐ Marriage* (35 days)
- ☐ Spouse/Retiree has different Open Enrollment period*+ (35 days)
- ☐ Spouse/Dependent loses other coverage* (35 days)
- ☐ Spouse/Dependent loses KCHIP/Medicaid coverage* (60 days)
- ☐ Spouse/Dependent loses other government group coverage* (35 days)
- ☐ Dependent re-establishes eligibility* (35 days)
- ☐ Other* _____

Event Date (mm/dd/yy): _____

**Supporting documentation and verification documents required*

PRINT the following information for each dependent to be added:

Social Security Number	Name (First, MI, Last)	Gender (Circle One)	Date of Birth	Relationship Code**
		M F		
		M F		
		M F		
		M F		

** Relationship Code: SP = Spouse / CH = Child / CO = Court Ordered Dependent / DD = Disabled Dependent

I acknowledge and understand that DEI will comply with the HIPAA Rules and that disclosure of information will be done under the rules of such Federal law. I further authorize DEI to use such information and to disclose such information to third party administrators, vendors, consultants, governmental authorities with jurisdiction and other necessary parties when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities.

My signature below certifies that I understand the statements on this form and that all the information provided by me is true and complete to the best of my knowledge. I understand that any person who knowingly and with intent to defraud any insurance company or other person, files this form containing any materially false information or conceals, with the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. I understand that any material misrepresentation or material omission contained herein may be used to void this contract.

_____ Applicant Signature _____ Date _____ Applicant's Insurance Coordinator Signature _____ Date

Signatures are required below if changes to an existing cross-reference plan are being requested.

_____ Spouse Signature _____ Date _____ Spouse's Insurance Coordinator Signature _____ Date