Kentucky Employees' Health Plan
Department of Employee Insurance
Enrollment Information Branch
(502)564-1205

2011 DEPENDENT DROP FORM

Give this form to your Insurance Coordinator

This form must be used for any qualifying event (QE) that allows you to drop dependents from your plan. (*You must complete an Enrollment Application to request other coverage election changes such as electing new coverage, option changes, new waiver or to cease a cross reference plan)*

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

Print Name (First, MI, Last) _____

To be eligible to drop a dependent from your health insurance plan, you must certify that you have experienced the QE as listed here.
By signing this form you are also certifying that you are not under any administrative order to cover the dependent(s) on your health insurance plan.

Qualifying Events: (Check one)

- ☐ Divorce*/Legal Separation*/ Annulment*(35 Days)
- ☐ Legal Guardianship/Admin Order/Court Order* +
- ☐ Spouse/Dependent/Retiree's Death
- ☐ Dependent child becomes ineligible (35 days)
- ☐ Spouse/Dependent gains employer-sponsored Group Coverage* (35 days)
- ☐ Sp/Dependent ends LWOP* (resumes coverage)
- ☐ Sp/Dep becomes eligible for Medicare* (35 days)
- ☐ Sp/Dep becomes eligible for Medicaid* (35) days
- ☐ Sp/Retiree has a different open enrollment period*+
- ☐ Other_____

Qualifying Event Date (mm/dd/yy): _____

Note: SP = Spouse DEP = Dependent

** Supporting documentation required*

+Refer to Administration Manual

NOTE: DEPENDENTS WILL BE DROPPED FROM YOUR PLAN AT THE END OF MONTH OF SIGNATURE DATE ON THIS FORM, BUT NOT BEFORE THE EVENT DATE.

Exceptions:

- ***Death:*** *dependent will be dropped effective the date of death.*
- ***Ineligible Dependents:*** *ineligible dependents will be dropped from the plan at the end of the month in which they became ineligible.*

PRINT the following information for each dependent to be dropped. If dropping self, you must complete an Enrollment Application.

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