Change of Address or Name Form Packet

Directions:

- If you are a **certified** employee, complete pages 2, 3, and 4.
- If you are a **classified** employee, complete pages 2, 3, and 5.

PAGE 2: Change of Address or Name Form - Complete the first page of this document with standard name or address change information. Sign and date the form; return to district.

Fax: 270.825.6183 | Email: janice.moore@hopkins.kyschools.us
Mail: Hopkins County Schools, 320 South Seminary Street, Madisonville KY 42431

PAGE 3: 2017 KEHP Update Form – This is the form that will be used to update information on health insurance, FSAs and HRAs. Complete the information, sign and date the form, and return to the district.
Fax: 270.825.6183 | Email: janice.moore@hopkins.kyschools.us
Mail: Hopkins County Schools, 320 South Seminary Street, Madisonville KY 42431

PAGE 4: Kentucky Teachers' Retirement System: Change of Address or Name Form – Complete this form if you are a certified employee. It is YOUR responsibility to return the form to KTRS.
Fax: 502.848.8599
Mail: Kentucky Teachers' Retirement System, 479 Versailles Road, Frankfort KY 40601

PAGE 5: Kentucky Retirement Systems: Change of Address Notification – Complete this form if you are a classified employee. It is YOUR responsibility to return the forms to KRS.
Fax: 502.696.8822 | Mail: Kentucky Retirement Systems, Perimeter Park West, 1260 Louisville Rd, Frankfort KY 40601-6124

For other Benefits packages:

- 5 Star Life Insurance - Contact the 5 Star Life Insurance Company (866-863-9753) and ask them to send you a Policy Change Form.
- American Fidelity - Visit their website at www.afadvantage.com for the necessary change forms.
- AFLAC - Visit their website at www.aflac.com for the necessary change forms.

Change of Address or Name Form Packet

This form is used to change your demographic data in Payroll and Benefits.

Fax: 270.825.6183 | Email: janice.moore@hopkins.kyschools.us

	CHANGE OF ADDRESS OR NAME **FROM**:
Name	
Address	
City/State/Zip	
Home Phone Number	
Email Address	

	CHANGE OF ADDRESS OR NAME **TO**:	
Name		
Address		
City/State/Zip		
Home Phone Number		
Email Address		
Please check accordingly	☐ Permanent Address OR	☐ Temporary Address

Check all that apply:

☐ I will contact the Benefits Office to change beneficiary information for life insurance and/or retirement.

☐ I will contact the Benefits Office to change optional insurance or other payroll deductions.

Signature ____ Date Signed __________________

Contact the Benefits Office: Phone 270-825-6100 Extension #22409 | Email janice.moore@hopkins.kyschools.us

Kentucky Employees' Health Plan
Department of Employee Insurance
Kehp.ky.gov • 1.888.581.8834

2018 EMPLOYEE HEALTH INSURANCE ENROLLMENT/CHANGE APPLICATION

Section 1: To Be Completed by IC/HRG – IN OFFICE USE ONLY

KHRIS Personnel Number	Organizational Unit #	Company Name	Hire/Transfer/Term Date	Coverage Effective Date	Company #	Cost Center #
	10006083	Hopkins County Bd of Ed			000265	9200100265

Note: Verification documents may be required; refer to the Administration Manual.

Reason(s) for Application:	Change in Employee Status:	Qualifying Event:		Termination or transfer
☐ New Hire	☐ Transfer	☐Marriage	☐ Begin Medicare/Medicaid	**If transfer:** This is to be completed by the **NEW** company & no changes to current coverage allowed.
☐ Rehire	☐ Begin LWOP	☐ Birth/Adoption/Placement	☐ End Medicare/Medicaid	Prior Company #:
☐ New Group	☐ End LWOP	☐ Court Order for Child	☐ Spouse/Dependent Starting Employment	Last Day worked:
☐ Qualifying Event	☐ Begin Military Leave	☐ Divorce	☐ Spouse/Dependent Terminating Employment	Coverage End date:
☐ Change or Update	☐ End Military Leave	☐ Death	☐ Other:	
☐ ACA	☐ Retired	☐ Loss of Individual Health		
☐ Grievance	☐ Termination	☐ Loss of Group Health		

Section 2: Demographic Information Changes or Current (Circle one)

Employee's SSN	Employee Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	Home County Code

Street Address	Primary Phone #	Work Email Address

City, State Zip	County	Secondary Phone #	Home Email Address

Sex: ☐Male ☐Female | Married: ☐Yes ☐No

Section 3: Spouse Information Changes or Current (Circle one)

Spouse's SSN	Spouse's Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	☐Add ☐ Drop ☐Remain	Sex ☐Male ☐ Female

☐ I wish to utilize the cross-reference payment option (two KEHP members, married with children – no LRP or JRP).

Spouse's Personnel Number	Spouse's Organizational Unit #	Spouse's Company #

Spouse's Phone #	Spouse's Home Email Address	Spouse's Work Email Address

Section 4: Dependent Information Changes or Current (Circle one)

SSN	Name	Date of Birth	Sex / Status	Action
Child #1 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	☐Male ☐Female ☐Disabled Dependent	☐Add ☐ Drop ☐Remain
Child #2 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	☐Male ☐Female ☐Disabled Dependent	☐Add ☐ Drop ☐Remain
Child #3 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	☐Male ☐Female ☐Disabled Dependent	☐Add ☐ Drop ☐Remain

Employee: **Employee SSN:**

Child #4 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	☐Male ☐Female ☐Disabled Dependent	☐Add ☐ Drop ☐Remain
Child #5 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	☐Male ☐Female ☐Disabled Dependent	☐Add ☐ Drop ☐Remain
Child #6 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	☐Male ☐Female ☐Disabled Dependent	☐Add ☐ Drop ☐Remain

Section 5: Tobacco Use Declaration Rules governing the Tobacco Use Declaration can be found in your Benefits Selection Guide or at kehp.ky.gov. You are eligible for the non-tobacco user premium contribution rates provided you certify that you or any other person to be covered under your plan has not regularly used tobacco within the past six months.

Planholder: Within the past 6 months, have you used tobacco regularly?
☐Yes ☐No
Has your spouse, if covered under this plan, used tobacco regularly within the past 6 months?
☐Yes ☐ No
Have any children covered under this plan, age 18 or older, used tobacco regularly within the past 6 months?
☐Yes ☐No

Section 6: Coverage Level

☐ Single (self only)	☐ Parent Plus (self and child(ren))	☐ Couple (self and spouse)	☐ Family (self, spouse and child(ren))

Section 7: Plan Options

☐ LivingWell CDHP ☐ I agree to the LivingWell Promise. Instructions on fulfilling your Promise can be found at LivingWell.ky.gov.
☐ LivingWell PPO ☐ I agree to the LivingWell Promise. Instructions on fulfilling your Promise can be found at LivingWell.ky.gov.
☐ Standard PPO
☐ Standard CDHP
☐ Waiver (General Purpose) HRA – with $ (I declare that I and, if applicable, my spouse and my dependents, have other group health plan coverage that provides minimum value. To the extent applicable, I have listed my spouse and all dependents whose medical expenses can be reimbursed under the HRA in Sections 3 and 4 of this application.)
My Group Health Plan Carrier:________________________________ **My Group Health Plan Policy Number:**____
☐ Waiver Dental/Vision ONLY HRA – with $
☐ Waiver without HRA – No $
☐ Default Standard PPO – IC/HRG use ONLY

Section 8: Signatures – Please submit this application to your Company IC/HRG By signing this application, I certify that the information provided in this application is true and correct to the best of my knowledge. I also certify that I have read, understand and agree to the Terms and Conditions of participation in the KEHP, the KEHP Legal Notices, and the Tobacco Use Declaration. These documents can be found in your Benefits Selection Guide or online at kehp.ky.gov.

By typing my name in the space provided below, I am signing this application electronically and am agreeing to conduct this transaction by electronic means.

Employee Signature | Spouse Signature – REQUIRED if electing cross-reference | Date

IC/HRG Signature | **Janice Moore** IC/HRG Printed Name | Date | **270-825-6000** IC/HRG Phone #

Spouse's IC/HRG Signature – REQUIRED if electing cross-reference | Spouse's IC/HRG Printed Name | Date | Spouse's IC/HRG Phone #

KENTUCKY TEACHERS' RETIREMENT SYSTEM

Change of Address or Name Form

As an active or retired teacher or survivor of a member of the Kentucky Teachers' Retirement System, I request that the information be changed as follows:

CHANGE ADDRESS or NAME *FROM*:

Name	
Address	
City/State/ZIP	
Home Phone Number	

CHANGE ADDRESS or NAME *TO*:

New Name	
New Address	
New City/State/ZIP	
New Phone Number	
Please Check Accordingly	____ **Permanent Address** **OR** ____ **Temporary Address**

The following information must be completed upon submission of this form.

County of Residence		
KTRS Member Identification Number		
Please CHECK one:	_____ **Active Member** _____ **Retired Member** _____ **Survivor**	***Send Beneficiary Change Form:*** ____ **yes** ____ **no**

*** A valid signature is required in order to process this change.**

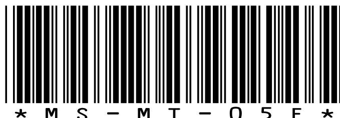
*** Signature is REQUIRED**	

PRINTED NAME of Member/Survivor's Signature

____

DATE

__________________ , 20 ___



Mail to: Kentucky Teachers' Retirement System
479 Versailles Road
Frankfort, KY 40601

Fax To: **Active Members**: 502/848-8599
Retired Members: 502/573-0199

Kentucky Retirement Systems
Perimeter Park West •1260 Louisville Rd. • Frankfort KY 40601-6124
Phone: (502) 696-8800 • Fax: (502) 696-8822 • kyret.ky.gov

Form 2040
Revised 10/2005

Change of Address Notification

In order for Kentucky Retirement Systems to insure proper mail delivery, please complete the following and return this form to our office as soon as possible.

Member Information Please provide your Member ID or Social Security number in the Member ID box below.

Member Name:		Member ID:	
Address:	City:	State:	Zip Code:
Daytime Phone Number:			

Please check the appropriate box below:

☐ Not receiving a monthly benefit (Active Member)
☐ Presently drawing a monthly benefit (Retired Member)

Important Notice

If a fiduciary is completing this change of address form on behalf of the member, a copy of the power of attorney, or order appointing guardianship, or other document, must be submitted with this form. Persons acting as a fiduciary should sign this and other retirement systems documents so that the capacity in which the document is being executed is exactly clear. If you are acting as a Power of Attorney, you must sign in the name of the principal followed by your signature as the attorney-in-fact with the designation “POA” or “AIF.” For example: “John Doe by Jane Doe, POA.” If you are acting as a Guardian, you must sign in the name of the ward followed by your signature as the guardian with the designation “Guardian.” For example: “John Doe by Jane Doe, Guardian.” If you have further questions, you may contact a counselor in writing or by telephone.

Kentucky Retirement Systems (KRS) addresses are now being updated monthly with the address on file for you with the U.S. Post Office. This is done through the National Change of Address (NCOA) system. Therefore, it is very important that you make sure your current address is on file with your local Post Office. Otherwise, when NCOA updates the KRS address records next month, your address may be replaced with an incorrect address; and mail from KRS may not be forwarded by the Post Office.

Signature: ______________________________ Date: ____________________