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

2019 FLEXIBLE SPENDING ACCOUNT (FSA) ENROLLMENT/CHANGE APPLICATION

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

KHRIS Personnel Number	Date of Hire	Effective Date	Organizational Unit #	Cost Center #	Company #

Section 2: To Be Completed by Employee

Employee's SSN	Name (Last, First, Middle)	Date of Birth

Street Address	City, State ZIP	Home County

Primary Phone #	Secondary Phone #	Email Address – preferably Work Email for notifications

Section 3: Enrollment Changes

Reason	If Qualifying Event, check item below	
☐ Rehire ☐ New Hire ☐ Open Enrollment ☐ New Group ☐ Qualifying Event (QE), Date: _____ ☐ Other Reason: _____	☐ Divorce/Legal Separation/Annulment* ☐ Death of a Child or Spouse* ☐ Loss of Eligibility ☐ Gaining/Losing Other Coverage (Medicare/Medicaid or any Government Group Health Insurance Coverage) ☐ Gaining/Losing Other Group Coverage ☐ Significant Cost Increase or Decrease for Dependent Care FSA*	☐ Marriage* ☐ Birth/Adoption of Child/Placement for Adoption* ☐ Guardianship/Court Order* ☐ Military Leave/Leave Without Pay Date: _____ ☐ Other Reason: _____ * Requires Supporting Documentation

Section 4: Enrollment Elections

Healthcare Flexible Spending Account

I request to **(check one)** ☐**Enroll** in or ☐**Change** my Healthcare FSA for calendar year 2019. I understand that the minimum allowable contribution is $10 per month ($5 per semi-monthly period).

Total Calendar Year Contribution*: $_____
**New hires should calculate year contribution from effective date to the end of the year.*

- Maximum calendar year contribution is $2,650 per eligible Planholder.
- Minimum calendar year contribution is $120 (or $10 per month).
- Enter an amount evenly divisible by 24. If not, DEI will adjust contribution amount.
- Maximum annual carryover amount is $500.
- Minimum annual carryover amount is $50.

Dependent Care Flexible Spending Account

I request to **(check one)** ☐**Enroll** in or ☐**Change** my Dependent Care FSA for calendar year 2019. I understand that the minimum allowable contribution is $10 per month ($5 per semi-monthly period).

Total Calendar Year Contribution*: $_____
**New hires should calculate year contribution from effective date to the end of the year.*

- Maximum contribution per tax filing status is $2,500 married filing separately, $5,000 married filing, or $5,000 married head of household.
- Minimum calendar year contribution is $120 (or $10 per month).
- Enter an amount evenly divisible by 24. If not, DEI will adjust contribution amount.
- For daycare expenses such as preschool, summer day camp, before/after school programs, and child or elder daycare.

Section 5: Signatures – Please submit this application to your Agency Insurance Coordinator

- 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 and the KEHP Legal Notices. These documents are located 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 Date

_____ _____ _____
IC/HRG Signature and Printed Name Date Telephone

Revised 09/12/2018