

**Goss  
Samford**

ATTORNEYS AT LAW | PLLC

**L. Allyson Honaker**  
allyson@gosssamfordlaw.com  
(859) 368-7740

RECEIVED

FEB 19 2020

PUBLIC SERVICE  
COMMISSION

February 19, 2020

***Via Hand-Delivery***

Kent Chandler  
Executive Director  
Kentucky Public Service Commission  
P.O. Box 615  
211 Sower Boulevard  
Frankfort, KY 40602

Re: In the Matter of: *Application of Knott County Water and Sewer District for an Alternative Rate Adjustment* - Case No. 2019-00268

Dear Mr. Chandler:

Enclosed please find for filing with the Commission in the above-referenced case an original and five copies of Knott County Water and Sewer District's ("KCWSD") proof of insurance termination for board members pursuant to ordering paragraph 8 of the Commission's January 31, 2020 Order..

Please do not hesitate to contact me if you have any questions.

Sincerely,



L. Allyson Honaker

Enclosures

# Transmission Report

RECEIVED

Date/Time  
Local ID 1

02-03-2020  
6066423770

15:00:47

Transmit Header Text  
Local Name 1

KCWSD Main Fax

FEB 19 2020

PUBLIC SERVICE  
COMMISSION

This document : Confirmed  
(reduced sample and details below)  
Document size : 8.5"x11"

7777 Big Branch Rd.  
Vesco, KY 41773  
Phone: (606) 642-3382  
Fax: (606) 642-3770

**Knott County Water  
& Sewer District**

# Fax

<b>To:</b>	Cris	<b>From:</b>	Kyle Smith
<b>Fax:</b>	(602) 664-5278	<b>Pages:</b>	2 + Cover Sheet
<b>Phone:</b>		<b>Date:</b>	2/3/2020
<b>Re:</b>	Spencer D. Hamilton Termination	<b>cc:</b>	
<input type="checkbox"/> Urgent <input type="checkbox"/> For Review <input type="checkbox"/> Please Comment <input type="checkbox"/> Please Reply <input type="checkbox"/> Please Recycle			

Cris,  
Thanks for taking the time to talk with me earlier and giving me instructions. I have attached the termination for Spencer D. Hamilton. I hope to have the other one ready to send to you soon.

Thanks,  
Kyle

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No.	Job	Remote Station	Start Time	Duration	Pages	Line	Mode	Job Type	Results
001	811	5025645278	14:30:42 02-03-2020	00:02:15	3/3	1	G3	HS	CP14400

## Abbreviations:

HS: Host send  
HR: Host receive  
WS: Waiting send

PL: Polled local  
PR: Polled remote  
MS: Mailbox save

MP: Mailbox print  
RP: Report  
FF: Fax Forward

CP: Completed  
FA: Fail  
TU: Terminated by user

TS: Terminated by system  
G3: Group 3  
EC: Error Correct

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## Knott County Water & Sewer District

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<b>Phone:</b>		<b>Date:</b>	2/3/2020
<b>Re:</b>	Spencer D. Hamilton Termination	<b>cc:</b>	

☐ Urgent    ☐ For Review    ☐ Please Comment    ☐ Please Reply    ☐ Please Recycle

Cris,

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Thanks,  
Kyle



**DO NOT STAPLE**

**2020 EMPLOYEE BENEFITS ENROLLMENT/CHANGE FORM**

Section 1: To be completed by the IC/HRG – IN OFFICE USE ONLY						
KHRIS Personnel # [REDACTED]	Organizational Unit # 10006311	Cost Center # 9200496554	Company Name Knott County Water & Sewer District	Agency # 060	Coverage Effective Date	Hire/QE/Transfer/Term Date 1/31/20
<b>Reason(s) for Application:</b> <input type="checkbox"/> New Hire <input type="checkbox"/> Rehire <input type="checkbox"/> New Group <input type="checkbox"/> Qualifying Event <input checked="" type="checkbox"/> Change or Update <input type="checkbox"/> ACA <input type="checkbox"/> Exception <input type="checkbox"/> Open Enrollment	<b>Change in Employee Status:</b> <input type="checkbox"/> Transfer <input type="checkbox"/> Begin LWOP <input type="checkbox"/> End LWOP <input type="checkbox"/> Begin Military Leave <input type="checkbox"/> End Military Leave <input type="checkbox"/> Retired <input checked="" type="checkbox"/> Termination	<b>Qualifying Event:</b> <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Marriage  <input type="checkbox"/> Birth/Adoption/Placement  <input type="checkbox"/> Court Order for Child  <input type="checkbox"/> Divorce  <input type="checkbox"/> Death  <input type="checkbox"/> Loss of Individual Health           </div> <div> <input type="checkbox"/> Loss of Group Health  <input type="checkbox"/> Begin Medicare/Medicaid  <input type="checkbox"/> End Medicare/Medicaid  <input type="checkbox"/> Sp/Dep Start Employment  <input type="checkbox"/> Sp/Dep Termed Employment  <input type="checkbox"/> Other: _____           </div> </div>				
<b>Transfer from one KEHP covered entity to another KEHP covered entity:</b> This section is to be completed by the NEW company & no changes to current coverage allowed. Prior Agency #: _____ Last Day Worked: _____						
Section 2: Employee Information – <input type="checkbox"/> Update my Demographics						
Employee's SSN [REDACTED]		Employee Name (Last, First, MI) Hamilton, Spencer D.		Date of Birth (mm/dd/yyyy) [REDACTED]		
Mailing Address 484 Dry Creek Road		City, State Zip Topmost, KY 41862		County Knott		
Primary Phone # (606) 447-2114		Secondary Phone # (606) 339-7730		Email Address-Preferably Work Email spencerh6205@yahoo.com		
Sex: <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		Married: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
Section 3: Spouse Information						
Spouse's SSN		Spouse's Name (Last, First, MI)		Date of Birth (mm/dd/yyyy)		
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Health <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain            Dental <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain            Vision <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain				
<input type="checkbox"/> 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 Hire Date		Spouse's Organizational Unit #		Spouse's Company #
Spouse's Primary Phone #		Spouse's Secondary Phone #		Spouse's Email Address-Preferably Work Email		
Section 4: Dependent Information				Health	Dental	Vision
Child #1 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Disabled Dependent	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain
Child #2 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Disabled Dependent	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain
Child #3 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Disabled Dependent	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain
Child #4 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Disabled Dependent	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain
Child #5 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Disabled Dependent	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain
Child #6 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Disabled Dependent	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain
Child #7 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Disabled Dependent	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain



Employee: Sprencer D. Hamilton

Employee SSN: [REDACTED]

**Section 5: Tobacco Use Declaration** Rules governing the Tobacco Use Declaration can be found online at [kehp.ky.gov](http://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: Health Insurance Plan Options**-All plans require the LivingWell Promise to receive the monthly premium discount of \$40 for the next plan year. Instructions and more information on fulfilling the LivingWell Promise can be found at [livingwell.ky.gov](http://livingwell.ky.gov).

☐ LivingWell CDHP ☐ LivingWell PPO ☐ LivingWell Basic CDHP ☐ LivingWell Limited High Deductible

☐ 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.)

Source of other coverage: ☐ Covered w/my spouse's employer (does not include TRICARE) ☐ Covered w/my parent's employer ☐ Dual group coverage/my own 2<sup>nd</sup> employer/retirement plan

*\*Note: if you have Medicaid, Medicare, TRICARE, Christian Healthcare Ministry, Veteran's Benefits or Individual Coverage w/Marketplace/Exchange, you are not eligible for the Waiver GP HRA but can elect the Waiver Dental/Vision ONLY HRA.*

☐ Waiver Dental/Vision ONLY HRA – with \$

☐ Waiver without HRA – No \$

☐ Default LivingWell Limited High Deductible – IC/HRG use ONLY – This should be used when a NEW HIRE does not submit an enrollment form or enroll online with KHRIS ESS.

**Select a Health Premium Level** ☐ Single (self only) ☐ Parent Plus (self + child(ren)) ☐ Couple (self and spouse) ☐ Family (self, spouse and child(ren))

#### Section 7: Anthem Dental Insurance Options

☐ Dental Bronze ☐ Dental Silver ☐ Dental Gold

#### Select a Dental Premium Level

☐ Single (self only) ☐ Parent Plus (self + child(ren))

☐ Couple (self and spouse) ☐ Family (self, spouse and child(ren))

#### Section 8: Anthem Vision Insurance Options

☐ Vision Bronze ☐ Vision Silver ☐ Vision Gold

#### Select a Vision Premium Level

☐ Single (self only) ☐ Parent Plus (self + child(ren))

☐ Couple (self and spouse) ☐ Family (self, spouse and child(ren))

#### Section 9: Flexible Spending Accounts

##### Healthcare Flexible Spending Account

I request to (check one) ☐ Enroll in or ☐ Change my Healthcare FSA for calendar year 2020. 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 \$2,700 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.

##### Child and Adult Daycare Flexible Spending Account

I request to (check one) ☐ Enroll in or ☐ Change my Child and Adult Daycare FSA for calendar year 2020. 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 10: 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 online at [kehp.ky.gov](http://kehp.ky.gov) and [personnel.ky.gov](http://personnel.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

*Kyle Smith*

IC/HRG Signature

Spouse Signature-REQUIRED if electing cross-reference

*Kyle Smith*

IC/HRG Printed Name

Date

*(606) 642-3582 2/3/20*

IC/HRG Phone#

Date

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

# Transmission Report

Date/Time  
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Kyle



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<b>Transfer from one KEHP covered entity to another KEHP covered entity:</b> This section is to be completed by the NEW company & no changes to current coverage allowed. Prior Agency #: _____ Last Day Worked: _____						
<b>Section 2: Employee Information – <input type="checkbox"/> Update my Demographics</b>						
Employee's SSN [REDACTED]		Employee Name (Last, First, MI) Smith, David K		Date of Birth (mm/dd/yyyy) [REDACTED]		
Mailing Address 474 Highway 1087 West		City, State Zip Leburn, KY 41831		County Knott		
Primary Phone # (606) 438-0031		Secondary Phone #		Email Address-Preferably Work Email		
Sex: <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		Married: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
<b>Section 3: Spouse Information</b>						
Spouse's SSN [REDACTED]		Spouse's Name (Last, First, MI) Smith, Ramona A		Date of Birth (mm/dd/yyyy) [REDACTED]		
Sex: <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female		Health <input type="checkbox"/> Add <input checked="" type="checkbox"/> Drop <input type="checkbox"/> Remain            Dental <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain            Vision <input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain				
<input type="checkbox"/> 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 Hire Date		Spouse's Organizational Unit #		Spouse's Company #
Spouse's Primary Phone #		Spouse's Secondary Phone #		Spouse's Email Address-Preferably Work Email		
<b>Section 4: Dependent Information</b>				Health	Dental	Vision
Child #1 SSN [REDACTED]	Name (Last, First, MI) Smith, Angelina K	Date of Birth (mm/dd/yyyy) [REDACTED]	<input type="checkbox"/> Male <input checked="" type="checkbox"/> Female <input type="checkbox"/> Disabled Dependent	<input type="checkbox"/> Add <input checked="" type="checkbox"/> Drop <input type="checkbox"/> Remain	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain
Child #2 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Disabled Dependent	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain
Child #3 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Disabled Dependent	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain
Child #4 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Disabled Dependent	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain
Child #5 SSN	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Disabled Dependent	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain	<input type="checkbox"/> Add <input type="checkbox"/> Drop <input type="checkbox"/> Remain
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Employee: David K. Smith

Employee SSN: [REDACTED]

**Section 5: Tobacco Use Declaration** Rules governing the Tobacco Use Declaration can be found online at [keh.ky.gov](http://keh.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: Health Insurance Plan Options** All plans require the LivingWell Promise to receive the monthly premium discount of \$40 for the next plan year. Instructions and more information on fulfilling the LivingWell Promise can be found at [livingwell.ky.gov](http://livingwell.ky.gov).

☐ LivingWell CDHP ☐ LivingWell PPO ☐ LivingWell Basic CDHP ☐ LivingWell Limited High Deductible

☐ 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.)

Source of other coverage: ☐ Covered w/my spouse's employer (does not include TRICARE) ☐ Covered w/my parent's employer ☐ Dual group coverage/my own 2<sup>nd</sup> employer/retirement plan

*\*Note: If you have Medicaid, Medicare, TRICARE, Christian Healthcare Ministry, Veteran's Benefits or Individual Coverage w/Marketplace/Exchange, you are not eligible for the Waiver GP HRA but can elect the Waiver Dental/Vision ONLY HRA.*

☐ Waiver Dental/Vision ONLY HRA – with \$

☐ Waiver without HRA – No \$

☐ Default LivingWell Limited High Deductible – IC/HRG use ONLY – This should be used when a NEW HIRE does not submit an enrollment form or enroll online with KHRIS ESS.

**Select a Health Premium Level** ☐ Single (self only) ☐ Parent Plus (self + child(ren)) ☐ Couple (self and spouse) ☐ Family (self, spouse and child(ren))

**Section 7: Anthem Dental Insurance Options**

☐ Dental Bronze ☐ Dental Silver ☐ Dental Gold

**Select a Dental Premium Level**

☐ Single (self only) ☐ Parent Plus (self + child(ren))

☐ Couple (self and spouse) ☐ Family (self, spouse and child(ren))

**Section 8: Anthem Vision Insurance Options**

☐ Vision Bronze ☐ Vision Silver ☐ Vision Gold

**Select a Vision Premium Level**

☐ Single (self only) ☐ Parent Plus (self + child(ren))

☐ Couple (self and spouse) ☐ Family (self, spouse and child(ren))

**Section 9: Flexible Spending Accounts**

**Healthcare Flexible Spending Account**

I request to (check one) ☐ Enroll in or ☐ Change my Healthcare FSA for calendar year 2020. 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 \$2,700 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.

**Child and Adult Daycare Flexible Spending Account**

I request to (check one) ☐ Enroll in or ☐ Change my Child and Adult Daycare FSA for calendar year 2020. 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 10: 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 online at [keh.ky.gov](http://keh.ky.gov) and [personnel.ky.gov](http://personnel.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

*Kyle Smith*

IC/HRG Signature

Spouse Signature-REQUIRED if electing cross-reference

*Kyle Smith*

IC/HRG Printed Name

*(606) 642-3582*

IC/HRG Phone#

Date

*2/4/2020*

Date

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

## Audit Report

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Subscriber name: David K Smith

Subscriber SSN: 402-86-4312

User	User Member Role	Member SSN	Member Name	Member Date of Birth	Eligibility Group	Date & Time	Enrollment Event	Action
MV_SYNC			Smith,David,K		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	06/01/2010 08:18 am	MV_SYNC	UPDATE Election
5632	BA		Angelina Smith		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	02/04/2020 12:14 pm	Terminate Subscriber	Update Dependent Dental Benefit
5632	BA		David Smith		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	02/04/2020 12:14 pm	Terminate Subscriber	Update Subscriber Vision Benefit
5632	BA		David Smith		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	02/04/2020 12:14 pm	Terminate Subscriber	Update Subscriber Marital Status,Smoke Indicator,Home Phone,Email Address,Marital Status Date,Language Indicator and Common Disable Indicator
5632	BA		Ramona Smith		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	02/04/2020 12:14 pm	Terminate Subscriber	Update Dependent Dental Benefit
5632	BA		David Smith		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	02/04/2020 12:14 pm	Terminate Subscriber	Update Subscriber Medical Prior Coverage
5632	BA		Ramona Smith		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	02/04/2020 12:14 pm	Terminate Subscriber	Update Dependent Vision Benefit
5632	BA		David Smith		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	02/04/2020 12:14 pm	Terminate Subscriber	Update Subscriber Dental Benefit
5632	BA		Angelina Smith		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	02/04/2020 12:14 pm	Terminate Subscriber	Update Dependent Vision Benefit

User	User Member Role	Member SSN	Member Name	Member Date of Birth	Eligibility Group	Date & Time	Enrollment Event	Action
MV_SYNC			Smith,David,K		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	06/01/2010 08:18 am	MV_SYNC	UPDATE Election
5632	BA		Angelina Smith		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	02/04/2020 12:14 pm	Terminate Subscriber	Update Dependent Dental Benefit
5632	BA		David Smith		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	02/04/2020 12:14 pm	Terminate Subscriber	Update Subscriber Vision Benefit
5632	BA		David Smith		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	02/04/2020 12:14 pm	Terminate Subscriber	Update Subscriber Marital Status,Smoke Indicator,Home Phone,Email Address,Marital Status Date,Language Indicator and Common Disable Indicator
5632	BA		Ramona Smith		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	02/04/2020 12:14 pm	Terminate Subscriber	Update Dependent Dental Benefit
5632	BA		David Smith		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	02/04/2020 12:14 pm	Terminate Subscriber	Update Subscriber Medical Prior Coverage
5632	BA		Ramona Smith		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	02/04/2020 12:14 pm	Terminate Subscriber	Update Dependent Vision Benefit
5632	BA		David Smith		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	02/04/2020 12:14 pm	Terminate Subscriber	Update Subscriber Dental Benefit
5632	BA		Angelina Smith		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	02/04/2020 12:14 pm	Terminate Subscriber	Update Dependent Vision Benefit

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Subscriber name: Spencer D Hamilton

Subscriber SSN: 400-08-1162

User	User Role	Member SSN	Member Name	Member Date of Birth	Eligibility Group	Date & Time	Enrollment Event	Action
5632 BA			Spencer Hamilton		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	02/03/2020 02:44 pm	Terminate Subscriber	Update Subscriber Smoke Indicator,Race,Address,Zip,Email Address,Language Indicator and Common Disable Indicator
5632 BA			Spencer Hamilton		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	02/03/2020 02:44 pm	Terminate Subscriber	Update Subscriber Vision Benefit
5632 BA			Spencer Hamilton		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	02/03/2020 02:44 pm	Terminate Subscriber	Update Subscriber Dental Benefit

User	User Role	Member SSN	Member Name	Member Date of Birth	Eligibility Group	Date & Time	Enrollment Event	Action
5632 BA			Spencer Hamilton		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	02/03/2020 02:44 pm	Terminate Subscriber	Update Subscriber Smoke Indicator,Race,Address,Zip,Email Address,Language Indicator and Common Disable Indicator
5632 BA			Spencer Hamilton		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	02/03/2020 02:44 pm	Terminate Subscriber	Update Subscriber Vision Benefit
5632 BA			Spencer Hamilton		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	02/03/2020 02:44 pm	Terminate Subscriber	Update Subscriber Dental Benefit

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Subscriber name: Gregory D Mullins

Subscriber SSN: 404-08-2926

User	User Member Role SSN	Member Name	Member Date of Birth	Eligibility Group	Date & Time	Enrollment Event	Action
LV_SYNC		Mullins, Gregory, D		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	11/13/2012 10:06 am	LV_SYNC	UPDATE Election
LV_SYNC		Mullins, Gregory, D		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	11/13/2012 10:06 am	LV_SYNC	SAVE Status
LV_SYNC		Mullins, Gregory, D		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	11/13/2012 10:06 am	LV_SYNC	SAVE Election
LV_SYNC		Mullins, Theresa, L		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	08/24/2012 11:40 pm	LV_SYNC	SAVE Dependent
5632	BA	Gregory Mullins		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	02/07/2020 08:51 am	Terminate Subscriber	Update Subscriber Vision Benefit
5632	BA	Theresa Mullins		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	02/07/2020 08:51 am	Terminate Subscriber	Update Dependent Vision Benefit
5632	BA	Theresa Mullins		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	02/07/2020 08:51 am	Terminate Subscriber	Update Dependent Dental Benefit
5632	BA	Gregory Mullins		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	02/07/2020 08:51 am	Terminate Subscriber	Update Subscriber Dental Benefit
5632	BA	Gregory Mullins		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	02/07/2020 08:51 am	Terminate Subscriber	Update Subscriber Zip, Email Address, Language Indicator and Common Disable Indicator

User	User Member Role SSN	Member Name	Member Date of Birth	Eligibility Group	Date & Time	Enrollment Event	Action
LV_SYNC		Mullins, Gregory, D		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	11/13/2012 10:06 am	LV_SYNC	UPDATE Election

LV_SYNC		Mullins,Gregory,D	799878- 79987801:KNOTT COUNTY WATER & SEWER DISTRICT	11/13/2012 LV_SYNC 10:06 am	SAVE Status
LV_SYNC		Mullins,Gregory,D	799878- 79987801:KNOTT COUNTY WATER & SEWER DISTRICT	11/13/2012 LV_SYNC 10:06 am	SAVE Election
LV_SYNC		Mullins,Theresa,L	799878- 79987801:KNOTT COUNTY WATER & SEWER DISTRICT	08/24/2012 LV_SYNC 11:40 pm	SAVE Dependent
5632	BA	Gregory Mullins	799878- 79987801:KNOTT COUNTY WATER & SEWER DISTRICT	02/07/2020 Terminate 08:51 am	Update Subscriber Subscriber Vision Benefit
5632	BA	Theresa Mullins	799878- 79987801:KNOTT COUNTY WATER & SEWER DISTRICT	02/07/2020 Terminate 08:51 am	Update Dependent Subscriber Vision Benefit
5632	BA	Theresa Mullins	799878- 79987801:KNOTT COUNTY WATER & SEWER DISTRICT	02/07/2020 Terminate 08:51 am	Update Dependent Subscriber Dental Benefit
5632	BA	Gregory Mullins	799878- 79987801:KNOTT COUNTY WATER & SEWER DISTRICT	02/07/2020 Terminate 08:51 am	Update Subscriber Subscriber Dental Benefit
5632	BA	Gregory Mullins	799878- 79987801:KNOTT COUNTY WATER & SEWER DISTRICT	02/07/2020 Terminate 08:51 am	Update Subscriber Subscriber Zip,Email Address,Language Indicator and Common Disable Indicator

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Subscriber name: Terry D Jacobs

Subscriber SSN: 400-17-6844

User	User Member Role SSN	Member Name	Member Date of Birth	Eligibility Group	Date & Time	Enrollment Event	Action
MV_SYNC		Jacobs, Heather, K		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	11/21/2017 06:07 am	MV_SYNC	SAVE Dependent
5632	BA	Terry Jacobs		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	01/16/2020 12:04 pm	Terminate Subscriber	Update Subscriber Dental Benefit
5632	BA	Heather Jacobs		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	01/16/2020 12:04 pm	Terminate Subscriber	Update Dependent Dental Benefit
5632	BA	Heather Jacobs		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	01/16/2020 12:04 pm	Terminate Subscriber	Update Dependent Vision Benefit
5632	BA	Terry Jacobs		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	01/16/2020 12:04 pm	Terminate Subscriber	Update Subscriber Name, Marital Status, Race, Zip and Home Phone
5632	BA	Terry Jacobs		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	01/16/2020 12:04 pm	Terminate Subscriber	Update Subscriber Vision Benefit

User	User Member Role SSN	Member Name	Member Date of Birth	Eligibility Group	Date & Time	Enrollment Event	Action
MV_SYNC		Jacobs, Heather, K		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	11/21/2017 06:07 am	MV_SYNC	SAVE Dependent
5632	BA	Terry Jacobs		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	01/16/2020 12:04 pm	Terminate Subscriber	Update Subscriber Dental Benefit
5632	BA	Heather Jacobs		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	01/16/2020 12:04 pm	Terminate Subscriber	Update Dependent Dental Benefit
5632	BA	Heather Jacobs		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	01/16/2020 12:04 pm	Terminate Subscriber	Update Dependent Vision Benefit
5632	BA	Terry Jacobs		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	01/16/2020 12:04 pm	Terminate Subscriber	Update Subscriber Name, Marital Status, Race, Zip and Home Phone
5632	BA	Terry Jacobs		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	01/16/2020 12:04 pm	Terminate Subscriber	Update Subscriber Vision Benefit

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