

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



FEB 19 2020

February 19, 2020

PUBLIC SERVICE COMMISSION

Via Hand-Delivery

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

#### In the Matter of: Application of Knott County Water and Sewer District for an Re: 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.

incerely. Amach

llyson Honaker

Enclosures

Date/Time Local ID 1

02-03-2020 15:00:47 6066423770

**Transmission Report** 

Local Name 1

**Transmit Header Text** 



FEB 19 2020

PUBLIC SERVICE COMMISSION

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

7777 Big Branch Rd. Vicco, KY 41773 Phone: (606) 642-3382 Fec: (608) 642-370

Knott County Water & Sewer District

KCWSD Main Fax



To:	Crits		From	Kyle Smith	
Fac	(602) 564-5278		Pages:	2 + Cover 8	Sheet
Phone:			Date:	2/3/2020	
Re:	Spencer D. Hamil	ton Termination	<b>CC:</b>		
Urgent	For Review	C Please Comme	nt CIPI	ease Reply	Please Recycle

Crits, 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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		PR: Polled rem									
						FA: Fail			63: Group 3		
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Re:	Spencer D. Hamil	ton Termination	CC:	<u></u>	<u></u>
	□ For Review	Please Comme	ent 🗆 Pi	ease Reply	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

### KENTUCKY PERSONNEL CABINET

### DO NOT STAPLE

## 2020 EMPLOYEE BENEFITS ENROLLMENT/CHANGE FORM

Section 1: To	be cor	npleted b	y the IC/HRG	i – IN (	OFFICE USE C	ONLY					
KHRIS	Organi	zational	Cost Center #	Com	ipany Name		Agency #	Cove	rage	Hire/QE/Trai	nsfer/Term
Personnel #	Unit #		9200496554	Kno	tt County Wate	er &	060	Effec	tive Date	Date1/31/20	
	10006	311		Sew	er District						
Reason(s) fo	r	Change i	n	Qual	ifying Event:						
<b>Application:</b>		Employe	e	🗆 Ma	rriage		Loss of Grou	p Health			
New Hire		Status:		🗆 Bir	th/Adoption/Pla	acement	Begin Medica	are/Medica	aid		
C Rehire		□ Transfe	r	□ Co	urt Order for Ch	ild	End Medicar	e/Medicai	đ		
New Group		Begin L		🗆 Div	orce		Sp/Dep Start	Employme	ent		
Qualifying Ev	vent			🗆 De	ath		Sp/Dep Term	ed Employ	ment		
A Change or U			lilitary Leave		ss of Individual H	lealth	Other:				
		a compare party of the manufactory of the	itary Leave	Tran	sfer from on	e KEHP	covered entit	v to ano	ther <b>KEHP</b>	covered ent	itv:
Exception		Retired					by the NEW cor	•			
Open Enrolli	nent	I Termina			Agency #:		t Day Worked:		•		
Section 2: Er	nploye	e Informat	tion - 🗆 Upd		y Demograpi						
	Employe				Employee Name	the second se	rst, MI)		Date of Bi	th (mm/dd/yy	(V)
					Hamilton,						
	Mailing	Address				ate Zip				County	
48	4 Dry Ci	reek Road			Topmost,	KY 4186	2			Knott	
	Primary	Concernance of the second s			Secondar			En	nail Address-	Preferably Wor	k Email
	(606) 44	7-2114			(606) 33	39-7730			spencerh6	205@yahoo.d	om
Sex: Male	Femal	e	1	Married	: 🛛 Yes 🖾 No						
Section 3: Sp	ouse Ir	formatio	n						_		
	Spouse	the second se			Spouse's Name	(Last, Fir	st. MI)		Date of Bi	th (mm/dd/yy	(V)
						•					
Sex: Male	Female	e	Health DAd			Dental 🗆	Add Drop DI	Remain V	ision 🗆 Add		nain
							with children -				
Spouse's Pe				se's Hir			e's Organization			pouse's Compa	nv #
						-				,	
Spouse's P	rimary Pl	none #	Spouse's S	ieconda	ry Phone #		Spouse's	Email Add	ess-Preferat	ly Work Email	
Section 4: De	enende	nt Inform:	ation						Health	Dental	Vision
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		ine (ease) i ins			(mm/dd/yyyy	)	The second second reader to the second second				
							Disabled De	ependent	Remain		
Child #2 SSN	Nar	ne (Last, Firs	it. MI)		Date of Birth		🗆 Male 🗆 Fe	male			
					(mm/dd/yyyy	)	Disabled De				
								pendent	Remain	Remain	
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		• · · · · · · · · · · · · · · · · · · ·			(mm/dd/yyyy	)	AND SPORTS A NEW			Drop	
									Drop Remain	Remain	
Child #4 SSN	Nar	ne (Last, Firs	it, MI)		Date of Birth		🗆 Male 🗆 Fe	male	Add	Add	DAdd
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					(mm/dd/yyyy	)	Disabled De	pendent	Drop	Drop	Drop
			•						Remain		Remain
Child #7 SSN	Nar	ne (Last, Firs	st, Mi)		Date of Birth		🗆 Male 🗆 Fe	male	Add	□Add	□Add
					(mm/dd/yyyy	)	Disabled De	nondant		Drop	Drop
								penuent	Remain		Remain

Section 5: Tobacco Use Declaration nutes governing the Tobacco Use Declaration can be found online at shepk your. You are eligible for the monotable cover permium contribution rates growlided you certify that you or any other person to be covered under your plan has not regularly used tobacco regularly?           Description         Description           We any children covered under this plan, age 18 or older, used tobacco regularly within the past 6 months?         Description           Intel we any children covered under this plan, age 18 or older, used tobacco regularly within the past 6 months?         Description           Intel we any children covered under this plan, age 18 or older, used tobacco regularly within the past 6 months?         Description           Intel we any children covered under this plan, age 18 or older, used tobacco regularly within the past 6 months?         Description           Uning well Control Uning well Control Integration on fulfilling the Uning well Control Integration on fulfilling the Uning well Control Integration on fulfilling the Uning well Control Integration on the enter applicable, have listed my spouses and all dependents whose medical expenses can be reimbursed under the HRA in Section 3 and 4 of this application.)           Source of other coverage:         Description           Integration         Description           Integration         Description           Integration of the HRA in Section 3 and 4 of this application.)         Source of ther coverage:         Covered w/my parent's employer in Dual group coverage my mont is section 3 and 4 of this application.)	Employee: Sprencer D. Hamilton	Employee SSN:
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Has you spoule, if covered under this plan, used tobacco regularly within the past 6 months?           Have any children covered under this plan, age 18 or older, used tobacco regularly within the past 6 months?           Section 6: Health Insurance Plan Options-All plans require the LivingWell Promite to receive the monthly premium discount of \$40 for the next plan year. Instructions and more information on fulfiling the LivingWell Dimited High Deductible           Water (General Purpose) HRA – with 5 (declare that 1 and, if applicable, ms youse and my dependents, have other group health plan coverage that povides motions 3 and 4 of this application.)           Source of the recoverage:         Covered w/ms yourse's employer (does not include TRICARE) Covered w/my parent's employer Dual group coverage/my own 2 <sup>st</sup> employer/returnement plan           *Note:         if you have Medical, Medicare, TRICARE, Christian Healthcare Ministry, Veteran's Benefits or Individual Coverage w/Monketplace/Exchange, you or an eligible for the Water of HAA but can elect the Water Omita/Vision ONLY HRA.           Water without HRA – Not 5         Section 7: Anthem Dental Insurance Options           Section 7: Anthem Dental Insurance Options         Section 8: Anthem Vision Rever Usion Gold Select a Media Spouse) D Family (self, spouse and child(ren))           Section 9: Anthem Dental Insurance Options         Section 9: Anthem Dental Insurance Options           Default LivingVell LivingKell Explosition is 520 (or 500 per month).         Child and Adult Daycare Flexible Spending Account           Irregues to (check one) DErnol in or DChange my Healthcare FSA for Calabaty yees 2020 LineGraft methal m	Planholder: Within the past 6 months, have you used tobacco regularly?	
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Univer         Delo           Section 5: Kealth 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 Hingwell Kygov.           UningWell CDHP         LivingWell PRO         LivingWell Promise can be found at Hingwell Kygov.           UningWell CDHP         LivingWell Basic CDHP         LivingWell Advecting the section 3 and 4 of this applicable, have listed my spouse and my dependents, have other group health plan coverage that provides minimum value. To the extent applicable, have listed my spouse and all dependents whose medical expenses can be reimbursed under the Hilk In Sections 3 and 4 of this application.)           Source of other coverage:         Covered w/my spouse's employer (dees not include TRICARE) Ciristian 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 Obent/Vision ONLY HRA = with 5         Default LivingWell Living HRA but can elect the Waiver Dental/Vision ONLY HRA.           Waiver Obent/Vision ONLY HRA = with 5         Default LivingWell Living HRA but can elect the Waiver Dental/Vision ONLY HRA.           Waiver Obent/Vision ONLY HRA = with 5         Section 5: Anthem Dental Insurance Options           Default LivingWell Living Leif Addites for a spouse)         Section 6: Anthem Vision Insurance Options           Couple (self and spouse)         Vision Braze Livision Sione apremoth is Solo of Select a Braith Premium Level		and a three with the second Concerning D
Section 6: Health Insurance Plan Options-AI plans require the LuingWell Promise to neache the month premium discount of \$40 for the nent plan year. Instructions and more information on fulfilling the UningWell Promise can be found at HumpwellAy gov.       LiningWell COHP	A STATE OF	gularly within the past 6 months?
next plane year. Instructions and more information on fulfilling the LivingWell Promise can be found at livingwell.ky-gov.         LivingWell CDHP L UniqWell Basic CDHP LuingWell Livite High Deductible         Waiver (General Purpose) HRA – with 5 ( dedare that 1 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 our are not eligible for the Waiver (Ref. Christion Healthcare Ministry, Veterar's Benefits or individual Coverage w/Marketplace/Exchange, you are not eligible for the Waiver of HRA but con elect the Woiver Dental/Vision ONLY HRA.         Waiver Control/Vision ONLY HRA – with 5       Waiver Ontal/Vision ONLY HRA – with 5         Waiver Control/Vision ONLY HRA – with 5       Section 7: Anthem NetBit Insurance Options         Select a Health Premium Level       Single (self only)       Parent Plus (self + child(ren))       Couple (self and spouse)       Family (self, spouse and child(ren))         Section 9: Anthem Dental Insurance Options       Vision Bronz:       Vision Silver Vision Sold       Vision Sold         Section 9: Flexible Spending Account       I request to (check one) DEnroll in or DChange my Healthcare FSA for clandar year contribution is 52,700 per eligible Planholder.       Note if your are contribution is 520 per month); section a spece to the day creat.<		in the line of the second in the menthly provide discount of the for the
LivingWell ChiP         LivingWell End ChiP		
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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 (my own 2 <sup>set</sup> employer/fettrement 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 Woiver GP HRA but can elect the Woiver Dental/Vision ONLY HRA.         Waiver Unit VIRA – with 5       Waiver Work HRA – No 5         Default LivingWell Limited High Deductible – IC/HRG use ONLY – This should be used when a NEW HIRE does not submit an enrollment form or enrollonine with KHRIS ESS.         Select a Health Premium Level		
under the HRA in Sections 3 and 4 of this application.)         Source of other coverage.    Covered w/my sparent's employer    Dual group         coverage w/more are 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 Woiver GP HRA but can elect the Woiver Dental/Vision ONLY HRA.         Waiver Challed, Medicare, TRICARE, Christian Healthcare Ministry, Veteran's Benefits or Individual Coverage w/Marketplace/Exchange, you are not eligible for the Woiver GP HRA but can elect the Woiver Dental/Vision ONLY HRA.         Waiver Challed, Wield 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 KIRIS ESS.         Select a Health Premium Level       Single (self only)         Single (self only)       Parent Plus (self + child(ren))         Couple (self and spouse)       Family (self, spouse and child(ren))         Section 3: Flaxible Spending Account       Select a Vision Bromer         Irequest to (check one) Clennol in or Dichange my Healthcare FSA for calendar year 2020. Lunderstand that the minimum allowable contribution is \$120 per month;         *New hires should calculate year contribution is \$2,700 per eligible Planholder.         •Naimum annual carryover amount is \$50.         *Naimum annual carryover amount is \$50.         *Naimum annual carryover amount is \$50.         *Naimum annual carryover amount is \$50.		
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>st</sup> employer/retirement plan         Notes:       By have Medicide, TRICARE, Christian Healthcare Ministry, Veteran's Benefits or Individual Coverage w/Marketplace/Exchange, you are not eligible for the Woiver GP HRA but can elect the Waiver Dental/Vision ONLY HRA.         Waiver Without HRA – Not       Waiver Without HRA – Not         Default LivingWell Limited High Deductible – IC/HRG use ONLY – This should be used when a NEW HIRE does not submit an enrollment form or enroil 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       Section 8: Anthem Vision Silver       Vision Good         Select a Health Premium Level       Single (self only)       Parent Plus (self + child(ren))       Couple (self and spouse)       Family (self, spouse and child(ren))         Section 9: Flexible Spending Account       Child and Adult Daycare Flexible Spending Account       Irequest to (check one) Elemonit and Adult         Irequest to (check one) Elemonit on Consenger working account is \$10 per month (S per semi-monthy period).       Total Calendar Year Contribution is \$2,700 per eligible Planholder.         •Maximum annual carroyver amount is \$500.       *New hires should calculate year contribution is \$2,700 per eligible Planholder.		spouse and an dependents whose medical expenses can be remoursed
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*Note: If you have Medicald, Medicare, TRICARE, Christian Healthcare Ministry, Veteran's Benefits or Individual Coverage w/Morketplace/Exchange, you are not eligible for the Waiver OP HRA but can elect the Waiver Dental/Vision ONLY HRA.         Waiver Central/Vision ONLY HRA – with S         Waiver Central/Vision ONLY HRA – with S         Below LivingWell Lumited High Deductible – IC/HRG use ONLY – This should be used when a NEW HIRE does not submit an enrollment form or enrollonile 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       Section 8: Anthem Vision Insurance Options       Vision Bronze Ulion Silver Ulion Gold         Select a Dental Premium Level       Single (self only) Parent Plus (self + child(ren))       Couple (self and spouse)       Family (self, child(ren))         Couple (self and spouse)       Family (self, spouse and child(ren))       Couple (self and spouse)       Family (self, child(ren))         Section 9: Flexible Spending Account       Irequest to (check one) Enroll in or Endange my Healthcare FSA for contribution is 510 per month (S5 per semi-month) period).       Child and Adult Daycare FSA for contribution is 5220. Understand that the minimum allowable contribution is 5220 or S10 per month).         • The and calculate year contribution is 5220 (or 510 per month).       • Nakimum calendary year contribution is 5220 (or 510 per month).         • Thew hires should calculate year contributio		tot include TRICARE) 🖬 Covered w/my parent's employer 🗋 Dual group
you are not eligible for the Waiver OF HRA but can elect the Waiver Dental/Vision ONLY HRA.         □ Waiver Unital/Nision ONLY HRA – with S         □ 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 KRBS 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 Silver □ Dental Silver □ Dental Gold       Section 8: Anthem Vision Insurance Options □ Vision Bronze □ Vision Silver □ Vision Silver □ Vision Gold         Select a Dental Premium Level □ Single (self only) □ Parent Plus (self + child(ren))       □ Single (self only) □ Parent Plus (self + child(ren))       □ Single (self only) □ Parent Plus (self + child(ren))         □ Couple (self and spouse) □ Family (self, spouse and child(ren))       □ Couple (self and spouse) □ Family (self, spouse and child(ren))         Section 9: Flexible Spending Account       I request to (check one) □Enroli In or □Change my Healthcare FSA for calendar year 2002. I understand that the minimum allowable contribution is \$10 per month).         Total Calendar Year contribution is \$2,700 per eligible Planholder.       •Minimum annual carryover amount is \$20.         •Maximum calendar year contribution is \$120 (or \$10 per month).       •Minimum annual carryover amount is \$50.         Section 10: Signatures - Please submit this application to your Company (C/HRG By signing this application, I certify that the information provided in this application is true and corr		
□ Waiver Dental/Vision ONLY HRA - with S         □ Waiver Vision ONLY HRA - with S         □ Befault LivingeWil 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         □ bental 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 9: Flexible Spending Account         Healthcare Flexible Spending Account         I request to (check one) □Enroll in or □Change my Healthcare F5A for Calendar year 2020. Understand that the minimum allowable contribution is 510 per month (S5 per semi-month) period). Total Calendar Year Contribution is 510 per month (S5 per semi-month) period). Total Calendar Year Contribution is 510 per month.         • Nawimum annual carryover amount is \$500.         • Namimum annual carryover amount is \$500.         • Mainmum annual carryover amount is \$50		
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	the for the Kulo S	mith 1606/642-3582 213/20
	IC/HRG Signature	

IC/HRG Phone#

Date

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

### **Date/Time** Local ID 1

02-04-2020 13:47:14 6066423770

**Transmission Report** 

**Transmit Header Text** Local Name 1

**KCWSD Main Fax** 

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

7777 Big Branch Rd. Vicza, KV 41773 Phone: (806) 642-3582 Fer: (806) 642-3770

Knott County Water & Sewer District



<u>Tq:</u>	Cris	P	rom	Kyle Smith	
Fax:	(502) 564-5278	P	ages:	2 + Cover S	Sheet
Phone:			ate:	2/4/2020	
Rei	David K. Smith Te	mination c	<b>C</b> I		
C Urgent	D For Review	CI Please Comment	C) PI	ease Reply	C Please Recycle

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

Thanks, Kyle

Total I	Pages Sc	canned : 3	Total Pages Confirmed : 3							
No.	Job	Remote Station	Start Time	Duration	Pages	Line	Mode	Job Type	Results	
001	821	5025645278	13:44:29 02-04-2020	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



To:	Cris		Fr	om:	Kyle Smith	
Fax:	(502) 564-5278		Pa	iges:	2 + Cover S	Sheet
Phone:			Da	ate:	2/4/2020	
Re:	David K. Smith Te	ermination	CO			. <u></u>
	G For Review	Please Con	nment		ease Reply	

Cris,

Thanks for taking the time to talk with me earlier and giving me instructions. I have attached the termination for David K. Smith. I hope to have the other one ready to send to you soon.

Thanks,

Kyle

# CABINET

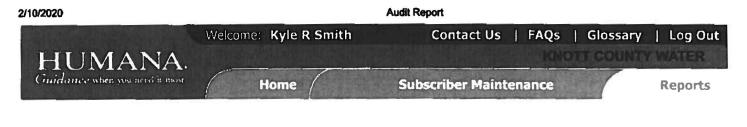
Department of Employee Insurance

### DO NOT STAPLE

2020 EMPLOYEE BENEFITS ENROLLMENT/CHANGE FORM

Section 1: To	be com	pleted b	the IC/HR	G – IN C	OFFICE USE O	NLY	······································		1-0404 011		
KHRIS	Organiz		Cost Center #	Com	pany Name		Agency #	Cover	-	Hire/QE/Tran	
Personnel #	Unit #		9200496554	Knot	tt County Wate	er &	96554	Effect	ive Date	Date01/31/2	020
	100063	11			er District			_			
Reason(s) fo	r	Change i	n	Qual	ifying Event:						
<b>Application:</b>	1	Employe	e		rriage						
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🗆 New Group		D Begin L	NOP	Div			Sp/Dep Start				
Qualifying E	vent		OP	Dea			Sp/Dep Term	ed Employ	ment		
Change or U	pdate	Begin M	lilitary Leave		is of Individual H		Other:				
		End Mili	itary Leave				covered entit				
		C Retired					by the NEW con	npany & no	changes to	current covera	ge allowed.
Open Enrolli	ment	I Termina	ition	Prior A	Agency #:	Las	t Day Worked:				
Section 2: Er	nployee	Informat	tion - 🗆 Up		y Demograph					····	
	Employee	e's SSN		,	Employee Name		rst, MI)		Date of Bi	rth (mm/dd/yy	(V)
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	Mailing A				City, St	no no no Recence a				County	
474		1087 Wes	t		Leburn, k					Knott	
	Primary P				Secondary	/ Phone #	•	Em	ail Address-	Preferably Wor	k Email
	(606) 438										
	Female			Married	Yes No						
Section 3: Sp	pouse Inf	formatio	n								
	Spouse's	s SSN			Spouse's Name		st, MI)		Date of Bi	rth (mm/dd/yy)	(Y)
					Smith, Ra						
Sex: Male										Drop Ren	nain
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Spouse's Pe	ersonnel Ni	umber	Spou	ise's Hire	e Date	Spous	e's Organizationa	l Unit #	\$	pouse's Compa	ny #
Spouse's P	rimary Pho	one #	Spouse's	Seconda	ry Phone #		spouse s	Email Addr	ess-Preferat	oly Work Email	
Section 4: De	ependen	t Informa	ation						Health	Dental	Vision
Child #1 SSN		e (Last, Firs			Date of Birth		🗆 Male 🛛 Fe	male	Add	Dbb	Add
	Smit	h, Angelina	ĸ		(mm/dd/yyyy)	1	Disabled De	pendent	⊠Drop		
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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. Lunderstand that the minimum allowable contribution is \$10 per month (\$5 per semi-monthly period).         Total Calendar Year Contribution*: \$	Employee: David K. Smith	Employee SSN:
tobacco within the past is months. Planbder: Within the past is months, have you used tobacco regularly within the past 6 months?  Pers_Do Per		
Planholder: Within the past 6 months, have you used tobacco regularly within the past 6 months? Pres	Towneys and the provide the second at the second of the second seco	or any other person to be covered under your plan has not regularly used
Image: Section 5:       No         Image: Section 6:       No         Section 6:       Health Insurance Plan Options: All plan require the UningWell Promise to receive the monthly premium discount of \$40         Image: Section 6:       Health Insurance Plan Options: All plan require the UningWell Promise can be found at UningWell.kry.gov.         Image: Section 6:       Health Insurance Plan Options: All plan require the UningWell Promise can be found at UningWell.kry.gov.         Image: Section 6:       Health Insurance Plan Options: All plan require the UningWell Promise can be found at UningWell.kry.gov.         Image: Section 6:       Health Insurance Options: Section 7:         Image: Section 6:       Health Insurance Options: TriACARE, Christian Healthcore Ministry, Veteran's Benefits or Individual Coverage w/Morketplace/E you are not eligible for the Waiver GP HAA but can elect the Waiver Dental/Vision ONUT HRA.         Image: Value Cherristic Christian Healthcore Ministry, Veteran's Benefits or Individual Coverage w/Morketplace/E you are not eligible for the Waiver GP HAA but can elect the Waiver Dental/Vision ONUT HRA.         Image: Waiver Generity Section 8: Antherm Wishon Other GP HAA but can elect the Waiver Dental/Vision ONUT HRA.       Image: Coverage w/Morketplace/E you now the KIRIS ESS.         Select A Health Premium Level Image: Select Options       Image: Select Option Image: Select Options Image: S		
Has your spouse, if covered under this plan, used tobacco regularly within the past 6 months?		
I're:       I're: <td< td=""><td></td><td>he auct 6 menths?</td></td<>		he auct 6 menths?
How any children covered under this plan, age 18 or older, used tobacco regularly within the past 6 months?           I'res         No           Section 6: Health Insurance Plan Options-All plans require the LivingWell Promise to receive the monthy premium discount of \$40 next plan year. Instructions and more information on fulfilling the LivingWell Promise to receive the monthy premium discount of \$40 to hext plan coverage/mole in the extent applicable, i have listed my spouse and my dependents, have other group health plan cover that provides minimum value. To the extent applicable, i have listed my spouse and my dependents, have other group health plan cover that provides minimum value. To the extent application.)           Source of other coverage:         Covered w/my spouse's employer (does not include TRICARE) Covered w/my parent's employer [Dual groverage/my on 2 <sup>44</sup> employer/retirement plan           *Note:         if you have Medicald, Medicare, TRICARE, Christian Healthcare Ministry, Veteron's Benefits or individual Coverage w/Marketplace/E you are not eligible for the Waver OP AIA but can elect the Walver Dentol/Vision ONLY HAL.           Waiver Oental/Vision ONLY HAL = with 5         Section 8: Anthem Vision Insurance Options           Default LivingWell Limited High Deductible = IC/HRG use ONLY - This should be used when a NEW HIRE does not submit an enrollment form enroll online with KRIS ESS.           Select a Health Premium Level         Single (self only) □ Parent Plus (self + child(ren))         Couple (self and spouse) □ Family (self, spouse and child(ren))           Couple (self and spouse) □ Family (self, spouse and child(ren))         Couple (self and spouse) □ Family (self, spouse and child(ren)) </td <td></td> <td>ne past o months?</td>		ne past o months?
Determine         Section 6: Health Insurance Plan Options-All plans require the LWingWell Promise to reactive the monthly premium discount of \$40 meta plan year. Instructions and more information on fulfilling the LWingWell Promise can be found at Iwingwell.ky.gov.           UningWell CMP         LWingWell BAB         LWingWell DMP         LWingWell BAB         LWingWell Immed Hab beductible           Walver (General Purpose) HAA - with 5 (defacts that 1 and, if applicable, my spouse and all dependents, have other group health plan coverage/my own 2 <sup>st</sup> employer (does not include TRICARE) Coverade w/my parent's employer Cloud group coverage/my own 2 <sup>st</sup> employer (feter that 1 and, if applicable, my spouses and all dependents, have other group health plan coverage/my own 2 <sup>st</sup> employer (feter meth plan 4 <sup>st</sup> of the watch of HAA to an elect the Walver Gen to Include TRICARE) Coverage w/Morketplace/E you are not eligible for the Walver Gen HAA to an elect the Walver Dental/Vision OMLY HRA.           Waiver Windout IRAA - with 5         Walver Windout IRAA - with 5           Walver Windout KIRAA - with 5         Select a Health Premium Level   Single (self only) P Parent Plus (self + child(ren))           Couple (self and spouse)   Farmily (self, spouse and child(ren))         Section 3: Anthem Vision Insurance Options           Section 7: Anthem Dental Insurance Options         Section 8: Anthem Vision Silver   Vision Gold           Select a Dental Promium Level         Single (self only) P arent Plus (self + child(ren))           Couple (self and spouse)   Farmily (self, spouse and child(ren))         Couple (self and spouse)   Farmily (self, spouse and child(ren))		gularly within the past 6 months?
Section 6: Health Insurance Plan Options-All plans require the LWingWell Promise to receive the monthly premium discount of \$40 next plan year. Instructions and more information on fulfilling the LWingWell Promise to found at lindigwell.Rydow. UkingWell Chef D LWingWell Basic CDPH UkingWell Englexable, my spouse and my dependents, have other group health plan cov that provides minimum value. To the extent applicable, have listed my spouse and all dependents whose medical expenses can be reimbu 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 g coverage/my on 2 <sup>w</sup> employer/retirement plan *Note: if you have Medicald, Medicare, TRICARE, Christian Healthcare Ministry, Veteran's Benefits or individual Coverage w/Marketplace/E you are not eligible for the Waiver OP HRA but can elect the Waiver Dental/Vision ONLY HRA. Waiver Obtal/Vision ONLY HRA – with 5 Default UniveWell Limited High Deductible – IC/HRG use ONLY – This should be used when a NEW HIRE does not submit an enrollment forr enroll online with KHRIS ESS. Select a Nealth 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 9: Anthem Dental Insurance Options Dental Bronze Dental Silver Contribution from effective date to the and of the year. *Nawimum calendary year contribution from effective date to the approxemation is 520 or Paranty set Silve Favor Silver Contribution is 520 or Paranty). *They hires should calculate year contribution from effective date to the year. *Nawimum calendary era contribution from effective date to the year. *Nawimum calendary era contribution f 550. *Maintum calendary area contribution from effective		Bornty mann are base a manalas.
next playear. Instructions and more information on fulfilling the UkingWell Emitted High Deductible         UningWell CMP       UvingWell PPO       LivingWell Basic CDMP         Waiver (General Purpose) HRA – with 5 (I decire that 1 and, II applicable, my spouse and all dependents, have other group health plan coverage/my own 2 <sup>st</sup> employer/retirement plan       wither (General Purpose) HRA – with 5 (I decire that 1 and, I applicable, my spouse and all dependents whose medical expenses can be reimbuunder 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 go coverage/my own 2 <sup>st</sup> employer/retirement plan         "Notes:       iyou howe Medicaicol, RICARE, Christian Healthcare Ministry, Veteran's Benefits or Individual Coverage w/Marketplace/E you are not eligible for the Waiver GP HRA but can elect the Waiver Dental/Vision ONLY HRA.         Waiver without HRA – No 5       Section 3: Anthem Next HIRE does not submit an enrollment form enrol online with KHRIS ESS.         Select a Health Premium Level       Single (self only)       Parent Plus (self + child(ren))       Couple (self and spouse)       Family (self, spouse i child(ren))         Section 9: Anthem Dental Insurance Options       Section 8: Anthem Vision Insurance Options       Section 9: Anthem Vision Sinder Curlson God         Single (self only)       Parent Plus (self + child(ren))       Couple (self and spouse)       Family (self, spouse and child(ren))         Couple (self and spouse)       Family (self		ing Well Promise to receive the monthly premium discount of \$40 for the
LivingWell COHP       LivingWell PDO       LivingWell Limited High Deductible         Waiver (General Purpose) HRA - with S (I declare that I and, if applicable, my spouse and my dependents, have other group health plan cover that provides minimum value. To the extent applicable, ihave spouse and all dependents whose medical expenses can be reimbut under the HRA in Sections 3 and 4 of this application.)         Source of other coverage:       Covered w/my sparent's employer   Dual gr coverage/my own 2 <sup>rd</sup> employer/retirement plan         "Note:       if you have Medicaid, Medicare, TRICARE, Christian Healthcare Ministry, Veteran's Benefits or Individual Coverage w/Marketplace/E you are not eligible for the Waiver GP HRA but can elect the Waiver Dental/Vision ONLY HRA.         Waiver Dental/Vision ONLY HRA - with S	•	•
□ Waiver (General Purpose) HRA - with \$ (I declare that I and, if applicable, my spouse and my dependents, have other group health plan cov         □ waiver (General Purpose) HRA - with \$ (I declare that I and, if applicable, I have listed my spouse and all dependents whose medical expenses can be reimbu         □ waiver of other coverage: □ Covered w/my spouse's employer (does not include TRICARE) □ Covered w/my parent's employer □ Dual gu coverage/my own 2 <sup>rd</sup> employer/retirement plan         □ waiver of other coverage: □ Covered w/my spouse's employer (does not include TRICARE) □ Covered w/my parent's employer □ Dual gu coverage/my own 2 <sup>rd</sup> employer/retirement plan         □ waiver without HRA - Not       □         □ Waiver without HRA - with \$       □         □ Waiver without HRA - Not \$       □         Select a Health Premium Level □ Single (self only □ Parent Plus (self + child(ren)) □ Couple (self and spouse) □ Family (self, spouse at child(ren))       □ Couple (self and spouse) □ Family (self, spouse and child(ren))         □ Section 7: Anthem Dental Insurance Options □       □ Section 8: Anthern Vision Insurance Options □         □ Single (self only □ Parent Plus (self + child(ren))       □ Couple (self and spouse) □ Family (self, spouse and child(ren))         □ couple (self and spouse) □ Family (self, spouse and child(ren))       □ Couple (self and spouse) □ Family (self, spouse and child(ren))         □ single (self only □ Parent Plus (self + child(ren))       □ Couple (self and spouse) □ Family (self, spouse and child(ren))         □ single (self only □ Parent Plus (self + child(ren))		
that provides minimum value. To the extent applicable, I have listed my spouse and all dependents whose medical expenses can be reimbuunder the HRA in Sections 3 and 4 of this application.)         Source of adher coverage: Covered w/my spouse's employer (does not include TRICARE) Covered w/my parent's employer Coverage/my own 2 <sup>rd</sup> employer/retirement plan <ul> <li>Note: if you have hedicial, Medicare, TRICARE, Christian Healthcore Ministry, Veteran's Benefits or Individual Coverage w/Marketplace/E you are not eligible for the Waiver Dental/Vision ONLY HRA – with S</li> <li>Waiver Dental/Vision ONLY HRA – with S</li> <li>Default Linygwell Linkled High Deductible – IC/HRG use ONLY – This should be used when a NEW HIRE does not submit an enrollment form enrollonline with KHRIS ESS.</li> <li>Select a Health Premium Level Single (self only) Parent Plus (self + child(ren))</li> <li>Couple (self and spouse) Family (self, spouse and child(ren))</li> <li>Section 7: Anthem Dental Insurance Options</li> <li>Dental Silver Chatal Sidve</li> <li>Single (self only) Parent Plus (self + child(ren))</li> <li>Couple (self and spouse) Family (self, spouse and child(ren))</li> <li>Socion 9: Flexible Spending Account</li> <li>Healthcoare Flexible Spending Account</li> <li>I request to (check one) Carontibution is 5120 (or 510 per month).</li> <li>Total Calendar vear contribution is 5220 (or 510 per month).</li> <li>Finanty during the splication, is 520.</li> <li>Maimum calendar vear contribution is 5120 (or 500 per month).</li> <li>Finanty and and that the minimum aliabuset contribution is 5120 (or 510 per month).</li> <li>Finanty and and this the polication. I certify that the minimum aliabuset or amount.</li> <li>Maximum annual carryover amount is 5500.</li> <li>Maimum calendar vear contribution is 512</li></ul>		
under the HRA in Sections 3 and 4 of this application.)         Source of other coverage:       Covered w/my parent's employer   Dual gr coverage/my oun 2 <sup>de</sup> employer/reitement plan         *Note: If you have Medicaid, Medicare, TRICARE, Christian Healthcare Ministry, Veteran's Benefits or Individual Coverage w/Marketplace/E you are not eligible for the Waiver OF HRA but can elect the Waiver Dental/Vision ONLY HRA.         Waiver Central/Vision ONLY HRA – with 5         Waiver Without HRA – No 5         Default Livingwell Limited High Deductible – IC/HRG use ONLY – This should be used when a NEW HIRE does not submit an enrollment form enroll online with KHRIS ESS.         Select a Health Premium Level   Single (self only)    Parent Plus (self + child(reni))    Couple (self and spouse)    Family (self, spouse a child/treni)         Section 7: Anthem Dental Insurance Options    Dental Arong Dental Singer    Dental Gold         Select a Health Premium Level    Single (self only    Parent Plus (self + child(reni))    Couple (self and spouse)    Family (self, spouse and child(reni))         Section 9: Hexible Spending Account I request to (check one)   Enroll in or IChange my Healthcare FSA for calendar year contribution is 510 erromoth (S5 per semi-monthy perio).         Total Calendar year contribution is 52,700 per eligible Planholder.         *Maximum calendar year contribution is 520 (or 530 per month).         *Inter an amount evenly divisible by 24. If not, DEI will adjust contribution sis 1520 (or 530 per month).         *Inter an amount evenly divisible by 24. If not, DEI will adjust con amount.         *Maxim		
Source of other coverage:       Coverage //my spouse's employer (does not include TRICARE)       Coverage/my own 2 <sup>ste</sup> employer/feittement plan         *Note:       ity how how Medical, REARE, Christian Healthcare Ministry, Veteran's Benefits or Individual Coverage w/Marketplace/E         you are not eligible for the Waiver GP HRA but can elect the Waiver Dental/Vision ONLY HRA.       Waiver Work With State Control Vision ONLY HRA.         Waiver Outsuch HRA - No 5       Default LivingWell Limited High Deductible - IC/HRG use ONLY - This should be used when a NEW HIRE does not submit an enrollment form enroll online with KHBI SSS.         Select a Health Premium Level       Single (self only)       Parent Plus (self + child(ren))       Couple (self and spouse)       Family (self, spouse at child(ren))         Section 7: Anthem Dental Insurance Options       Section 8: Anthem Vision Insurance Options       Section 9: Anthem Vision Gold         Select a Dental Premium Level       Single (self only)       Parent Plus (self + child(ren))       Couple (self and spouse)       Family (self, spouse and child(ren))         Couple (self and spouse)       Framily (self, spouse and child(ren))       Couple (self and spouse)       Family (self, spouse and child(ren))         Calendar Year Contribution is 510 per month (SS per semi-monthy period).       Child and Adult Daycare Flexible Spending Account         Irequest to (check one)       Enrol Plane, Brexible Spending Account       Irequest to (check one) Enrolli on Clanage my Child and Adult Not period (ling or \$5,000 married		
coverage/my own 2** employer/retirement plan         *Note: If you have Medicaid, Medicare, TRICARE, Christian Healthcare Ministry, Veteran's Benefits or Individual Coverage w/Marketplace/E         you are net leighte for the Waiver OP HRA but can elect the Waiver Dental/Vision ONLY HRA.         Waiver Dental/Vision ONLY HRA – with S         Waiver Dental/Vision ONLY HRA – No S         Default LivingWell Limited High Deductible – IC/HRG use ONLY – This should be used when a NEW HIRE does not submit an enrollment formeroll online with KHRS 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       Section 8: Anthern Vision Insurance Options       Vision Bronze – Vision Silver – Vision 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 9: Flexible Spending Account       Irequest to (check one) Enroll in or Change my Healthcare FSA for calendar year 2020. Lunderstand that the minimum allowable contribution is 510 per month (S5 per semi-monthy period).         Total Calendar year contribution from effective date to the end of the year.       New Inters should calculate year contribution form effective date of the year.         •Maximum calendar year contribution is 520, 00r S500       Si per emoth (S 5 per semi-month).         •Child andAdu Daycare FA for calendar year contribution form effective dat	••	ot include TRICARE) Covered w/my parent's employer C Dual group
*Note: if you have Medicaid, Medicare, TRICARE, Christian Healthcare Ministry, Veteran's Benefits or Individual Coverage w/Marketplace/E         you are not eligible for the Waiver GP HRA but can elect the Waiver Dental/Vision ONLY HRA.         Waiver Without HRA – No 5         Default LivingWell Limited High Deductible – IC/HRG use ONLY – This should be used when a NEW HIRE does not submit an enrollment forre 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 at child(ren))         Section 7: Anthem Dental Insurance Options       Section 8: Anthem Vision Insurance Options       Vision Bronze       Vision Bronze       Vision Boilver       Vision Gold         Select a Dental Fremium Level       Single (self only)       Parent Plus (self + child(ren))       Couple (self and spouse)       Family (self, spouse and child(ren))         Couple (self and spouse)       Family (self, spouse and child(ren))       Couple (self and spouse)       Family (self, spouse and child(ren))         Section 9: Flexible Spending Account       Irequest to (check one) Enroil in or Change my Healthcare FSA for calendar year contribution is 520 per month).       Child and Adut Daycare Flexible Spending Account         Irequest to (check one) Enroil in surfamer of the year.       Maximum calendar year contribution is 52,000 per religible Planholder.         • Minimum calendar year contribution is 52,000 per religible Planholder.       • Minim		
you are not eligible for the Waiver GP HRA but can elect the Waiver Dental/Vision ONLY HRA.         Waiver Dental/Vision ONLY HRA – No S         Default UvingWell Limited High Deductible – IC/HRG use ONLY – This should be used when a NEW HIRE does not submit an enrollment form 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       Section 8: Anthem Vision Insurance Options       Section 9: Anthem Vision Silver       Vision Storac       Vision Storac       Setist and spouse)       Family (self, spouse and child(ren))         Couple (self and spouse)       Family (self, spouse and child(ren))       Couple (self and spouse)       Family (self, spouse and child(ren))         Section 9: Flexible Spending Accounts       Child and Adult Daycare Flexible Spending Account I request to (check one) Earnol in or Echange my Child and Adu Daycare FSA for calendary vear 2020. Lunderstand that the minimum allowable contribution is 510 per monthy period).       Total Calendar Year Contribution from effective date to the end of the year.       •New hires should calculate year contribution is 520.00 per month).         •Maximum calendar year contribution is 520.00       File and anount.       •New hires should calculate year contribution is 520.00 or 510 per month).         •Maximum annual carryover amount is 550.       •New hires should calculate year contribution is 520.00 (rs 10 per month).       •Mainum annual c		Ainistry Veteran's Renefits or Individual Coverane w/Marketnlace/Evchance
□ Waiver verthout HRA – No S         □ Default LivingWeil Limited High Deductible – IC/HRG use ONLY – This should be used when a NEW HIRE does not submit an enrollment form 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 at 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 9: Flexible Spending Account         Healthcare Flexible Spending Account         I request to (check one) □Enroll in or □Change my Healthcare FSA for calendar year contribution is \$120 for \$10 per month.         Total Calendar Year Contribution is \$2,700 per eligible Planholder.         •Naminum calendary ear contribution from effective date to the vear.         •Naw inins annual carryover amount is \$20.0 per soligible Planholder.         •Ninimum annual carryover amount is \$500.         •Naminum annual car	• •	
□ 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 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 a child(ren))         Section 7: Anthem Dental Insurance Options       □ Dental Silver □ Dental Gold         □ Dental Bronze □ Dental Silver □ Dental Gold       Section 8: Anthem Vision Insurance Options         □ Single (self only) □ Parent Plus (self + child(ren))       □ Couple (self and spouse) □ Family (self, spouse and child(ren))         □ Couple (self and spouse) □ Family (self, spouse and child(ren))       □ Couple (self and spouse) □ Family (self, spouse and child(ren))         □ Single (self only) □ Parent Plus (self + child(ren))       □ Couple (self and spouse) □ Family (self, spouse and child(ren))         □ Sougle (self and spouse) □ Family (self, spouse and child(ren))       □ Couple (self and spouse) □ Family (self, spouse and child(ren))         Section 9: Flexible Spending Account       I request to (check one) □Enroll in or □Change my Healthcare FSA for calendar year Contribution from effective date to the era or the should calculate year contribution from effective date to the era or the should calculate year contribution from effective date to the era of the year.         • Maximum calendar year contribution is \$120 (or \$10 per month).       • Total Calendar year contribution for the S50.         • Maimum annual carryover amount is \$50.       • Mi	<ul> <li>Control design and the second state of the second sta</li></ul>	
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Select a Health Premium Level       Single (self only)       Parent Plus (self + child(ren))       Couple (self and spouse)       Pamily (self, spouse a child(ren))         Section 7: Anthem Dental Insurance Options       Section 8: Anthem Vision Insurance Options       Vision Bioner       Vision Gold         Dental Bronze       Dental Silver       Dental Gold       Vision Bronze       Vision Gold         Select a Dental Premium Level       Single (self only)       Parent Plus (self + child(ren))       Couple (self and spouse)       Pamily (self, spouse and child(ren))         Section 9: Flexible Spending Accounts       Child and Adult Daycare Flexible Spending Account       Irequest to (check one)       Enroll in or Change my Child and Adult Daycare Flexible Spending Account         I request to (check one)       Enroll in or Change my Child and Adult Daycare Flexible Spending Account       Irequest to (check one)       Enroll in or Change my Child and Adult Daycare Flexible Spending Account         * New hires should calculate year contribution is \$120 per month/server       **       **       **         * Namium calendar year contribution is \$2,700 per eligible Planholder.       **       **       **         * Maximum calendar year contribution is \$2,200 per eligible Planholder.       *       *       *         * Maximum calendar year contribution is \$2,200 per eligible Planholder.       *       *       *         * Maximum calendary y	The second	ould be used when a NEW HIRE does not submit an enrollment form or
child(ren))         Section 7: Anthem Dental Insurance Options         Dental Bronze       Dental Silver         Dental Bronze       Dental Silver         Dental Bronze       Dental Gold         Select a Dental Premium Level       Single (self only)         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 Accounts         Healthcare Flexible Spending Account         I request to (check one) Enroll in or EChange my Healthcare FSA for calendar year 2020.1 understand that the minimum allowable contribution is \$10 per month (55 per semi-monthly period).         Total Calendar Year Contribution from effective date to the end of the year.         *New hires should calculate year contribution is \$2,700 per eligibe Planholder.         *Minimum calendar year contribution is \$220 (or \$10 per month).         *Enter an amount evenly divisible by 24. If not, DEI will adjust contribution a s520.00         *Maximum annual carryover amount is \$500.         *Minimum annual carryover amount is \$500.         *Minimum annual carryover amount is \$500.         *Minimum annual carryover amount is \$50.         *Maximum annual carryover amount is \$50.         *Maximum annual carryover amount is \$50.         *Maximum annual carr		
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□ 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))       □ Couple (self and spouse)       □ Family (self, spouse and child(ren))         □ Section 9: Flexible Spending Accounts       □ Couple (self and spouse)       □ Family (self, spouse and child(ren))         □ Couple (self and spouse)       □ Family (self, spouse and child(ren))       □ Couple (self and spouse)       □ Family (self, spouse and child(ren))         Section 9: Flexible Spending Account       I request to (check one)       □ Child and Adult Daycare Flexible Spending Account         I request to (check one)       □ In or □ Change my Healthcare FSA for calendar year 2020. I understand that the minimum allowable contribution is \$10 per month (S5 per semi-monthly period).         Total Calendar Year Contribution is \$2,700 per eligible Planholder.       •New hires should calculate year contribution is \$120 (or 510 per month).         • Maximum calendar year contribution is \$52,700 per eligible Planholder.       •Ninimum annual carryover amount is \$500.         • Minimum annual carryover amount is \$500.       •Minimum annual carryover amount is \$500.         • Minimum annual carryover amount is \$50.       •For daycare expenses such as preschool, summer day camp. befor anount.         • Moximum annual carryover amount is \$50.       •For daycare expenses such as preschool,	child(ren))	
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Single (self only) Parent Plus (self + child(ren)) Section 9: Flexible Spending Accounts Healthcare Flexible Spending Accounts Healthcare Flexible Spending Accounts Healthcare Flexible Spending Account I request to (check one) Enroll in or Echange my Healthcare FSA for calendar year 2020. 1 understand that the minimum allowable contribution is \$10 per month (55 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. *Maximum calendar year contribution is \$2120 (or \$10 per month). *Enter an amount evenly divisible by 24. If not, DEI will adjust contribution amount. *Maximum annual carryover amount is \$500. *Maximum annual carryover amount is \$500. *Minimum calendar year contribution is true and correct to the best of my knowledge. I also certify that I have read, understand and agree to Terms and Conditions of participation in the KEHP, the KEHP Legal Notices, and the Tobacco Use Declaration. These documents can be found or keps.ky.gov and personnel.ky.gov. By typing my name in the space provided below, I am signing this application electronically and am agreeing conduct this transaction by electronic means. Employee Signature Spouse Signature-REQUIRED if electing cross-reference Date	•	
□ Couple (self and spouse) □ Family (self, spouse and 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 *: \$	Select a Dental Premium Level	Select a Vision Premium Level
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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. •Minimum annual carryover amount is \$50. •Moximum annual carryover amount is \$50. •Minimum annual carryover amount is \$50. •Moximum annual carryover amount is \$50. •Terms and Conditions of participation is true and correct to the best of my knowledge. I also certify that I have read, understand and agree to Terms and Conditions of participation in the KEHP. the KEMP Legal Notices, and the Tobacco Use Declaration. These documents can be found or kehp.ky.gov and personnel.ky.gov. By typing my name in the space provided below, I am signing this application electronically and am agreeing conduct this transaction by electronic means. Employee Signature For daycare. Employee Signature •Moximum annual carryower amount and agree to Spouse Signature-REQUIRED if electing cross-reference •Date 2/4/20		
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<ul> <li>amount.</li> <li>Maximum annual carryover amount is \$500.</li> <li>Minimum annual carryover amount is \$50.</li> <li>Minimum annual carryover amount is \$50.</li> <li>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 Terms and Conditions of participation in the KEHP, the KEHP Legal Notices, and the Tobacco Use Declaration. These documents can be found or kehp.ky.gov and personnel.ky.gov. By typing my name in the space provided below, I am signing this application electronically and am agreeing conduct this transaction by electronic means.</li> <li>Employee Signature</li> <li>Spouse Signature-REQUIRED if electing cross-reference</li> <li>Date</li> <li>Will SMith SMith</li></ul>	•Minimum calendar year contribution is \$120 (or \$10 per month).	separately, \$5,000 married filing, or \$5,000 married head of household.
<ul> <li>Maximum annual carryover amount is \$500.</li> <li>Minimum annual carryover amount is \$50.</li> <li>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 Terms and Conditions of participation in the KEHP, the KEHP Legal Notices, and the Tobacco Use Declaration. These documents can be found or kehp.ky.gov and personnel.ky.gov. By typing my name in the space provided below, I am signing this application electronically and am agreeing conduct this transaction by electronic means.</li> <li>Employee Signature</li> <li>Spouse Signature-REQUIRED if electing cross-reference</li> <li>Date</li> <li>Wayde Smith</li> </ul>		•Minimum calendar year contribution is \$120 (or \$10 per month).
<ul> <li>Minimum annual carryover amount is \$50.</li> <li>For daycare expenses such as preschool, summer day camp, befor school programs, and child or elder daycare.</li> <li>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 Terms and Conditions of participation in the KEHP, the KEHP Legal Notices, and the Tobacco Use Declaration. These documents can be found or kehp.ky.gov and personnel.ky.gov. By typing my name in the space provided below, I am signing this application electronically and am agreeing conduct this transaction by electronic means.</li> <li>Employee Signature</li> <li>Spouse Signature-REQUIRED if electing cross-reference</li> <li>Date</li> <li>Walk Smith</li> <li>Mylk Smith</li> <li>(404) 642-3582</li> <li>2/4/20</li> </ul>		
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conduct this transaction by electronic means.         Employee Signature         Spouse Signature-REQUIRED if electing cross-reference         Date         Lyle         Smith         (60%)642-3582         2/4/20		
Tyle Smith Kyle Smith (606)642-3582 2/4/20	conduct this transaction by electronic means.	
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IC/HRG/Signature IC/HRG Printed Name IC/HRG Phone# Date	IC/HRGSignature	
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Spouse's IC/HRG Signature-REQUIRED if electing cross-reference Spouse's IC/HRG Printed Name IC/HRG Phone# Date	Snouse's IC/HRG Signature, REOLURED if electing cross-reference. Snouse's 1	C/HRG Printed Name IC/HRG Phonett Data



Print Page

Subscriber name: David K Smith Subscriber SSN: 402-86-4312

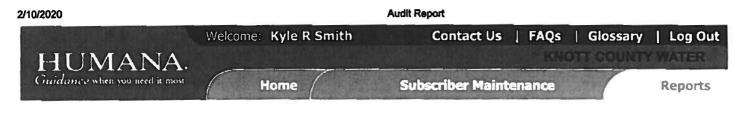
User		Member SSN	Namo	Member Date of Birth	Eligibility Group	Date & Time	Enrollment Event	Action
MV_SYNC			Smith,David,K		799878- 79987801:KNOTT COUNTY WATER & SEWER DISTRICT		MV_SYNC	UPDATE Election
5632	BA		Angelina Smith		799878- 79987801:KNOTT COUNTY WATER & SEWER DISTRICT			Update Dependent Dental Benefit
5632	BA		David Smith		799878- 79987801:KNOTT COUNTY WATER & SEWER DISTRICT			Update Subscriber Vision Benefit
5632	BA		David Smith			02/04/2020 12:14 pm	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			Update Dependent Dental Benefit
5632	BA		David Smith		799878- 79987801:KNOTT COUNTY WATER & SEWER DISTRICT	02/04/2020 12:14 pm		Update Subscriber Medical Prior Coverage
5632	BA		Ramona Smith		799878- 79987801:KNOTT COUNTY WATER & SEWER DISTRICT			Update Dependent Vision Benefit
5632	BA		David Smith		799878- 79987801:KNOTT COUNTY WATER & SEWER DISTRICT			Update Subscriber Dental Benefit
5632	BA		Angelina Smith		THE REAL PROPERTY OF THE PROPERTY OF THE REAL PROPE			Update Dependent Vision Benefit

https://enrolfmentba.humana.com/Reports/ViewAuditReport.aspx

User		Member SSN	Member Name	Member Date of Birth	Eligibility Group	Date & Time	Enroliment Event	Action
MV_SYNC			Smith,David,K		799878- 79987801:KNOTT COUNTY WATER & SEWER DISTRICT		MV_SYNC	UPDATE Election
5632	BA		Angelina Smith		799878- 79987801:KNOTT COUNTY WATER & SEWER DISTRICT			Update Dependent Dental Benefit
5632	BA		David Smith		799878- 79987801:KNOTT COUNTY WATER & SEWER DISTRICT			Update Subscriber Vision Benefit
5632	BA		David Smith		799878- 79987801:KNOTT COUNTY WATER & SEWER DISTRICT		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		Update Dependent Dental Benefit
5632	BA		David Smith		799878- 79987801:KNOTT COUNTY WATER & SEWER DISTRICT			Update Subscriber Medical Prior Coverage
5632	BA		Ramona Smith		799878- 79987801:KNOTT COUNTY WATER & SEWER DISTRICT			Update Dependent Vision Benefit
5632	BA		David Smith		799878- 79987801:KNOTT COUNTY WATER & SEWER DISTRICT			Update Subscriber Dental Benefit
5632	BA		Angelina Smith		799878- 79987801:KNOTT COUNTY WATER & SEWER DISTRICT			Update Dependent Vision Benefit

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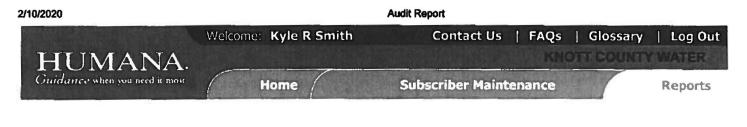
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Subscriber name: Spencer D Hamilton Subscriber SSN: 400-08-1162

User User Role	Member SSN	Mémber Nama	Member Date of Birth	Eligibility Group	Date & Time	Enroliment Event	Action
5632 BA		Spencer Hamilton			02/03/2020 02:44 pm	Subscriber	Update Subscriber Smoke Indicator, Race, Address, Zip, Email Address, Language Indicator and Common Disable Indicator
5632 BA		Spencer Hamilton			02/03/2020 02:44 pm	Terminate Subscriber	Update Subscriber Vision Benefit
5632 BA		Spencer Hamilton			02/03/2020 02:44 pm	Terminate Subscriber	Update Subscriber Dental Benefit

	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	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 Memi Role SSN	<sup>ber</sup> 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		Update Subscriber Vision Benefit
5632	BA	Theresa Mullins		799878- 79987801:KNOTT COUNTY WATER & SEWER DISTRICT	02/07/2020 08:51 am		Update Dependent Vision Benefit
5632	BA	Theresa Mullins		799878- 79987801:KNOTT COUNTY WATER & SEWER DISTRICT			Update Dependent Dental Benefit
5632	BA	Gregory Mullins		799878- 79987801:KNOTT COUNTY WATER & SEWER DISTRICT	02/07/2020 08:51 am		Update Subscriber Dental Benefit
5632	BA	Gregory Mullins		799878- 79987801:KNOTT COUNTY WATER & SEWER DISTRICT	02/07/2020 08:51 am	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	E.	799878- 79987801:KNOTT COUNTY WATER & SEWER DISTRICT	11/13/2012 10:06 am	LV_SYNC	UPDATE Election

10/2020			Audit Report		
LV_SYN	1C	Mullins,Gregory,D	799878- 79987801:KNOTT COUNTY WATER & SEWER DISTRICT	11/13/2012 LV_SYNC 10:06 am	SAVE Status
LV_SYN	IC .	Mullins, Gregory, D	799878- 79987801:KNOTT COUNTY WATER & SEWER DISTRICT	11/13/2012 LV_SYNC 10:06 am	SAVE Election
LV_SYN	IC	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 Subscriber	Update Subscriber Vision Benefit
5632	BA	Theresa Mullins	799878- 79987801:KNOTT COUNTY WATER & SEWER DISTRICT	02/07/2020 Terminate 08:51 am Subscriber	
5632	BA	Theresa Mullins	799878- 79987801:KNOTT COUNTY WATER & SEWER DISTRICT	02/07/2020 Terminate 08:51 am Subscriber	
5632	BA	Gregory Mullins	799878- 79987801:KNOTT COUNTY WATER & SEWER DISTRICT	02/07/2020 Terminate 08:51 am Subscriber	
5632	BA	Gregory Mullins	799878- 79987801:KNOTT COUNTY WATER & SEWER DISTRICT	02/07/2020 Terminate 08:51 am Subscriber	Update 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 Role	Member SSN	Member Name	Member Date of Birth	Eligibility Group	Date & Time	Enroliment 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	ŝ,	Terry Jacobs		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT			Update Subscriber Dental Benefit
5632	BA		Heather Jacobs		99878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT			Update Dependent Dental Benefit
5632	BA		Heather Jacobs		99878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT			Update Dependent Vision Benefit
5632	BA		Terry Jacobs	-	99878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	and the second sec	and the second	Update Subscriber Name,Marital Status,Race,Zip and Home Phone
5632	BA		Terry Jacobs		99878-79987801:KNOTT OUNTY WATER & EWER DISTRICT			Update Subscriber Vision Benefit

User	User Membe Role SSN	<sup>er</sup> 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			Update Subscriber Dental Benefit
5632	BA	Heather Jacobs		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT			Update Dependent Dental Benefit
5632	BA	Heather Jacobs		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	the first of the second s		Update Dependent Vision Benefit
5632	BA	Terry Jacobs		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT	1000 Mar. 200		Update Subscriber Name,Marital Status,Race,Zip and Home Phone
5632	BA	Terry Jacobs		799878-79987801:KNOTT COUNTY WATER & SEWER DISTRICT			Update Subscriber Vision Benefit

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