

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

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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	CC:		
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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						FA: Fail			63: Group 3		
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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:						
Application:		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		
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		a compare party of the manufactory of the	itary Leave	Tran	sfer from on	e KEHP	covered entit	v to ano	ther KEHP	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			
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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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The Smith Kyle Smith (606)642-3582 213/20	conduct this transaction by electronic means.	
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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	C 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,

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Thanks,

Kyle

CABINET

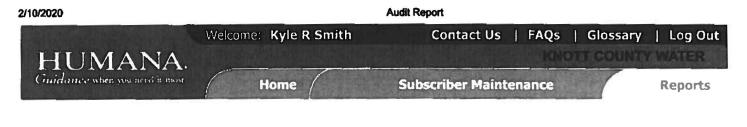
Department of Employee Insurance

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		
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		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:				
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	(606) 438										
	Female			Married	Yes No						
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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))	
Select a Dental Premium Level 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 Child and Adult Daycare Flexible Spending Account Healthcare Flexible Spending Accounts Child and Adult Daycare Flexible Spending Account I request to (check one) Enroll in or ClChange 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 *: \$ *Mem bires should calculate year contribution from effective date to the ear. *Maximum calendar year contribution is \$10 opr month (\$5 per semi-monthly period). *New bires should calculate year contribution is \$2,700 per eligible Planholder. *Minimum calendar year contribution is \$2,700 per eligible Planholder. *Maximum calendar year contribution is \$2,000 per month). *Enter an amount evenly divisible by 24. If not, DEI will adjust contribution manunt. *Maximum annual carryover amount is \$500. *Minimum annual carryover amount is \$500. *Minimum annual carryover amount is \$500. *Minimum annual carryover amount is \$500. *Minimu 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 o	Section 7: Anthem Dental Insurance Options	Section 8: Anthem Vision Insurance Options
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
□ 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 *: \$	Single (self only) Parent Plus (self + child(ren))	□ Single (self only) □ Parent Plus (self + child(ren))
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 *: \$		Couple (self and spouse) C Family (self, spouse and child(ren))
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*: \$	Costion O: Elevible Creading Assourts	
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calendar year 2020. I understand that the minimum allowable contribution is \$10 per month (\$5 per semi-monthly period). Total Calendar Year Contribution*: \$		
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. *Nakimum calendar year contribution is \$2,700 per eligible Planholder. *Minimum calendar year contribution is \$2,700 per eligible Planholder. *Minimum calendar year contribution is \$2,700 per eligible Planholder. *Minimum calendar year contribution is \$2,700 per eligible Planholder. *Minimum calendar year contribution is \$2,700 per eligible Planholder. *Maximum annual carryover amount is \$500. *Minimum annual carryover amount is \$500. *Minimum annual carryover amount is \$50. *Section 10: Signatures – Please submit this application to your Company IC/HRG By signing this application, I certify that the and 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. Employee Signature Spouse Signature-REQUIRED if electing cross-reference Date Mult Smith Q/4/2.0	CONTRACTOR CONTRACTOR AND A CONTRACTOR OF A CONTRA	
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. *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. Employee Signature Signature Spouse Signature-REQUIRED if electing cross-reference Date With Signature Agreement Signature Ag		The set is herein in the employer is more the set another a the interview of the strength interview is the set of the set
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		
 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. 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. Employee Signature Spouse Signature Spouse Signature-REQUIRED if electing cross-reference Date My Company Company	CONSISTENT PROPERTY AND AND A CONSISTENCE AND A	
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 amount. Maximum annual carryover amount is \$500. Minimum annual carryover amount is \$50. Minimum annual carryover amount is \$50. 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. Employee Signature Spouse Signature-REQUIRED if electing cross-reference Date Will SMith SMith	•Minimum calendar year contribution is \$120 (or \$10 per month).	separately, \$5,000 married filing, or \$5,000 married head of household.
 Maximum annual carryover amount is \$500. Minimum annual carryover amount is \$50. 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. Employee Signature Spouse Signature-REQUIRED if electing cross-reference Date Wayde Smith 		•Minimum calendar year contribution is \$120 (or \$10 per month).
 Minimum annual carryover amount is \$50. For daycare expenses such as preschool, summer day camp, befor 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 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. Employee Signature Spouse Signature-REQUIRED if electing cross-reference Date Walk Smith Mylk Smith (404) 642-3582 2/4/20 		
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 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. Employee Signature Spouse Signature-REQUIRED if electing cross-reference Date Will Smith (606)642-3582 2/4/20		
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. Employee Signature Spouse Signature-REQUIRED if electing cross-reference Date Way Smatch Date U/4/20	-imminum annual carryover amount is 550.	
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. Employee Signature Spouse Signature-REQUIRED if electing cross-reference Date Wyle Smith (606)642-3582 2/4/20	Section 10: Signatures - Please submit this application to you	
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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.	
Tyle Smith Kyle Smith (606)642-3582 2/4/20	Employee Signature	re PEQUIPED if electing cross-reference
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	hule Smith hule S	mith (10, No.) (042-3582 2/4/2020
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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

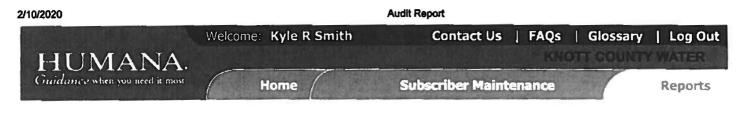
User		Member SSN	Namo	Member Date of Birth	Eligibility Group	Date & Time	Enrollment Event	Action
MV_SYNC			Smith,David,K		799878- 79987801:KNOTT COUNTY WATER & SEWER DISTRICT		MV_SYNC	UPDATE Election
5632	BA		Angelina Smith		799878- 79987801:KNOTT COUNTY WATER & SEWER DISTRICT			Update Dependent Dental 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

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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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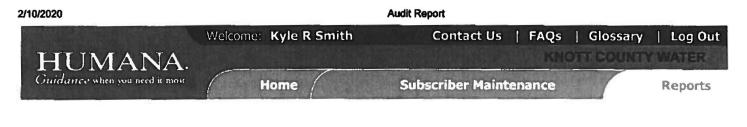
Print Page

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	^{ber} 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	^{er} 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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