

CLASSIFIED EMPLOYEES

Change of Address or Name Form Packet

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

Complete and return via fax, email, or mail.

Fax: 270.825.6183 | Email: carrie.slaton@hopkins.kyschools.us

Mail: Hopkins County Schools, 320 South Seminary Street, Madisonville KY 42431

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

CHANGE ADDRESS OR NAME <u>TO:</u>	
Name	
Address	
City/State/Zip	
Home Phone Number	
Email Address	
Please check accordingly	<input type="checkbox"/> Permanent Address OR <input type="checkbox"/> Temporary Address

Check all that apply:

- I will contact the Benefits Office to change beneficiary information for life insurance and/or retirement.
- I will contact the Benefits Office to change optional insurance or other payroll deductions.

Signature _____ Date Signed _____

Contact the Benefits Office: Phone 270-825-6100 Extension #2409 | Email carrie.slaton@hopkins.kyschools.us

Change of Address or Name Information

Complete the next two forms and submit as directed below.

1. 2013 KEHP Update Form – This is the form that will be used to update information on health insurance, FSAs and HRAs. Complete the information, sign and date the form, and return to the district.
Fax: 270.825.6183 | Email: carrie.slaton@hopkins.kyschools.us
Mail: Hopkins County Schools, 320 South Seminary Street, Madisonville KY 42431
2. Kentucky Retirement Systems: Change of Address Notification – Complete this form if you are a classified employee. It is YOUR responsibility to return the forms to KRS.
Fax: 502.696.8822 | Mail: Kentucky Retirement Systems, Perimeter Park West, 1260 Louisville Rd, Frankfort KY 40601-6124



2013 KEHP UPDATE FORM

To be completed by Insurance Coordinator/HR Generalist only. DO NOT use this form to add or drop dependents.
 This form is to be used to update information on health insurance, FSA and HRAs.

General Information (required)			
Name:	Personnel Number:	SSN:	
Organizational Unit:	Company Number:	Company Name:	
Update Reason			
<input type="checkbox"/> Termination: Date Employment Ends _____ Date Health Insurance Terminates _____ Reason: <input type="checkbox"/> Resigned <input type="checkbox"/> Retired <input type="checkbox"/> LWOP <input type="checkbox"/> Death <input type="checkbox"/> Military Leave <input type="checkbox"/> Other _____			
<input type="checkbox"/> Reinstate Coverage: Date Returned to Work _____ Date Insurance Effective _____ Reason: <input type="checkbox"/> Rehired <input type="checkbox"/> FMLA <input type="checkbox"/> LWOP <input type="checkbox"/> Military Leave <input type="checkbox"/> Other _____			
<input type="checkbox"/> Transfer or Summer Transfer <ul style="list-style-type: none"> ▪ To be completed by the NEW company ▪ No changes to current coverage allowed 			
Prior Company Number _____		New Company Number _____	
Last Day Worked at Prior Company _____		Date Hired at New Company _____	
Coverage End Date at Prior Company _____		Coverage Begin Date at New Company _____	
Is Member Cross Reference <input type="checkbox"/> Yes <input type="checkbox"/> No	Current Benefit Option <input type="checkbox"/> Commonwealth Standard PPO <input type="checkbox"/> Commonwealth Maximum Choice <input type="checkbox"/> Commonwealth Capitol Choice <input type="checkbox"/> Commonwealth Optimum PPO	Current Coverage Level <input type="checkbox"/> Single (self only) <input type="checkbox"/> Parent Plus (self and child(ren)) <input type="checkbox"/> Couple (self and spouse) <input type="checkbox"/> Family (self, spouse and child(ren))	
Other Changes or Corrections			
For: <input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)			
Name	New:		
	Previous:		
New Address (where mail received)	Street Address:		
	City:	State:	Zip Code:
E-Mail Address			
SSN	Correct:	Incorrect:	
Date of Birth	Correct:	Incorrect:	
Other			

I acknowledge and understand that DEI will comply with HIPAA rules and that disclosure of information will be done under the rules of such Federal law. I further authorize DEI to use such information and to disclose such information to third party administrators, vendors, consultants, governmental authorities with jurisdiction and other necessary parties when necessary for my care or treatment, payment for services, the operation of my health plan or to conduct related activities.

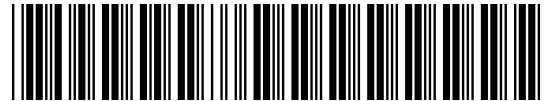
Employee Signature	Date
Insurance Coordinator/HRG Signature	Date

Insurance Coordinator/HRG: Mail this form to DEI, 501 High Street, 2nd Floor, Frankfort, KY 40601



Kentucky Retirement Systems

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



Form 2040
Revised 10/2005

Change of Address Notification

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

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

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

Please check the appropriate box below:

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

Important Notice

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

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

Signature: _____

Date: _____