Hopkins County Schools
Every Child • Every Effort • Every Day

CERTIFIED 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 **FROM**:	
Name	
Address	
City/State/Zip	
Home Phone Number	
Email Address	

CHANGE ADDRESS OR NAME **TO**:	
Name	
Address	
City/State/Zip	
Home Phone Number	
Email Address	
Please check accordingly	☐ Permanent Address OR ☐ 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.slation@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 Teachers' Retirement System: Change of Address or Name Form – Complete this form if you are a certified employee. *It is YOUR responsibility to return the form to KTRS.*
   Fax: 502.848.8599 | Mail: Kentucky Teachers' Retirement System, 479 Versailles Road, Frankfort KY 40601

Do Not Staple

Kentucky Employees' Health Plan
Department of Employee Insurance
KEHP.KY.GOV ● 1-888-581-8834

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

❑ **Termination:** **Date Employment Ends** _____ **Date Health Insurance Terminates** _____

Reason: ❑ Resigned ❑ Retired ❑ LWOP ❑ Death ❑ Military Leave ❑ Other _____

❑ **Reinstate Coverage:** **Date Returned to Work** _____ **Date Insurance Effective** _____

Reason: ❑ Rehired ❑ FMLA ❑ LWOP ❑ Military Leave ❑ Other _____

❑ **Transfer or Summer Transfer**

- 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
❑ Yes ❑ No

Current Benefit Option
❑ Commonwealth Standard PPO
❑ Commonwealth Maximum Choice
❑ Commonwealth Capitol Choice
❑ Commonwealth Optimum PPO

Current Coverage Level
❑ Single (self only)
❑ Parent Plus (self and child(ren))
❑ Couple (self and spouse)
❑ Family (self, spouse and child(ren))

Other Changes or Corrections

For: ❑ **Member** ❑ **Spouse** ❑ **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 TEACHERS' RETIREMENT SYSTEM

Change of Address or Name Form

As an active or retired teacher or survivor of a member of the Kentucky Teachers' Retirement System, I request that the information be changed as follows:
(A valid signature is required in order to process this change.)

CHANGE OF ADDRESS or NAME FROM:

Name	
Address	
City/State/ZIP	
Home Phone Number	

CHANGE ADDRESS or NAME TO:

New Name	
New Address	
New City/State/ZIP	
New Phone Number	
Please Check Accordingly	_____ Permanent Address OR _____ Temporary Address

The following information must be completed upon submission of this form.

County of Residence	
KTRS Member Identification Number	
Please circle one: Active or Retired	*Send Beneficiary Change Form:* ____ yes ____ no
Member/Survivor's Signature	
Date	_____ , 20_____

Return to:
Kentucky Teachers' Retirement System
479 Versailles Road
Frankfort, KY 40601

FAX to:
Active Members FAX to: 502/848-8599
Retired Members FAX to: 502/573-0199