KENTUCKY PERSONNEL CABINET | Department of Employee Insurance

EXCEPTION FORM

Fax to: 502-564-5278

Today's Date:
Effective Date of Requested Change:

PLANHOLDER'S PERSONAL INFORMATION

Name and mailing address	
	Telephone Number
	SSN
	KHRIS Per Nr

Agency/Employer Name	Agency Number
Agency Insurance Coordinator/HR Name	

REASON FOR EXCEPTION REQUEST *(Must include the appropriate enrollment application or the exception request will not be reviewed)*

TO BE COMPLETED BY THE DEPARTMENT OF EMPLOYEE INSURANCE

Date Received: Date of Decision:

Approved: ☐ Denied: ☐ Effective Date of Change:

(Approved exceptions are effective the 1st day of the month following the signature date of the exception request)

Reason if denied:

- ☐ Required document(s) not attached
- ☐ Request conflicts with state and/or federal laws
- ☐ Filed past 60-days of the event date
- ☐ No exception to the LivingWell Promise
- ☐ No extenuating circumstance
- ☐ Other