



**State Employee Health Plan (SEHP)  
 Prescription Drug Advance Purchase Certificate  
 PLEASE FAX COMPLETED FORM TO: 785-368-7180**

<b>Agency Name</b>	<b>Agency Number</b>
<b>Member's Name</b>	<b>Member's Social Security Number</b>
<b>State Employee Identification Number</b>	<b>Work Phone with Area Code</b>
<b>Home Phone with Area Code</b>	<b>Email Address</b>
<b>Extended Absence Dates – Departure Date</b>	<b>Return Date</b>
<b>Extended Absence Location</b>	

**Prescription(s) Information:**

<b>Patient Name</b>	<b>Drug Information (name, strength, dosage, directions)</b>	<b>Prescribing Physician Name</b>

**Participating Pharmacy Name And Phone Number**

**Participating Pharmacy Address**

**Member's Certification**

I am an employee of the State of Kansas and the employee identified above and signed below. I hereby certify that coverage will be maintained via payroll deductions for all family members requesting advance prescriptions for the entire period of the extended absence. I understand that the benefits available during my extended absence will be limited to those benefits which are payable under the plan within the United States for prescription drug coverage.

If, for any reason, I discontinue my coverage or coverage for my dependant(s) during the extended absence or if employment with the Agency and the State of Kansas is terminated, I acknowledge that I will be responsible for repaying the cost of the benefits and services advanced for me and/or my family members.

<b>Signature of Employee</b>	<b>Date</b>
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**Agency Representative's Certification**

I am the undersigned Agency Representative. I hereby certify that the above-named employee will be on extended absence for the period stated above; that plan coverage will be maintained during that period; and that both Agency and employee contributions will be made by regular, bi weekly payroll deductions for the duration of the extended absence. If the employment relationship is terminated or if coverage is dropped during the extended absence, the Agency will be responsible for repaying the State Employee Health Plan for the costs of any premiums due; of any services paid in advance; and for any necessary collections activity required to recover such costs from the former employee. The Agency I represent will assume all responsibility for communicating with the employee regarding coverage, continuing coverage via payroll deductions, and collections.

<b>Signature and Title of Group Administrator</b>	<b>Date</b>
<b>Email Address</b>	<b>Phone</b>