

**KANSAS STATE EMPLOYEE HEALTH CARE COMMISSION
EMPLOYEE ADVISORY COMMITTEE**

Nominee Information Form

Name: _____
Agency: _____
Position: _____
Agency Address: _____

E-Mail Address: _____
County of Residence: _____
County of Work: _____
Work Phone: _____
Fax: _____

Length of State Service: _____ **Salary Tier:** (circle one)
- less than \$27,000;
- at least \$27,000 but
less than \$47,000;
- over \$47,000

Gender (circle one): Male / Female **Age:** (circle one)
20-30
31-40
41-50
51-64
65 or older

Health Plan: _____

Coverage Type:
Employee Only _____
Employee & Spouse Only _____
Employee & Child(ren) Only _____
Employee with Spouse & Child(ren) _____

Why are you interested in serving as a member on the Employee Advisory Committee?

RETURN TO:
Kansas Health Policy Authority
State Employee Health Plan - ATTN: EAC
Room 900 North
900 SW Jackson
Topeka, Kansas 66612-1251
Fax: 785-368-7180