UK UNIVERSITY OF KENTUCKY Human Resources

Health, Dental, and Vision Plan Enrollment Form 2015–2016

Office Use Only
Pers.No
Eff. Date

EMPLOYEE INFORMATION Please Print or type

Last Name	First Name	MI	Person ID or Soc.Sec.#	Preferred Email

Home Address	City	State	Zip Code	Home Phone	Work Phone	Status
						□ UK □ KCTCS □ CKMS □ ESH

REASON FOR APPLICATION (CHECK ONE)

__New Enrollment

__Open Enrollment

__Change of Enrollment (Select reason of change)**

****Reason for change**

__Marriage
__Birth/Adoption
__Divorce
__Death
__Dependent no longer eligible for coverage
__Family judgement, decree or court order
__Open Enrollment for Spouse
__Change in employment status of spouse or emp.: Separation date from UK (If applicable)_____

Supporting documentation will be required

HEALTH PLAN

___UK-HMO (Lexington Service Area)
___UK-RHP (Regional Health Plan)
___UK-PPO
___UK-EPO
___UK Indemnity
___No Health Coverage
___No Changes

LEVEL OF COVERAGE

___Emp. Only
___Emp. + Spouse/Spons. Dependent
___Emp. + Child(ren)
___Emp. + Family
___Emp. + Family with/ Combined Credit**
**Social Security # or UK ID of Spouse:_____

DENTAL PLAN

___Delta Dental Basic
___Delta Dental Enhanced
___UK Dental Care Basic
___UK Dental Care Comprehensive
___No Dental Coverage
___No Changes

LEVEL OF COVERAGE

___Emp. Only
___Emp. + Spouse/Spons. Dependent
___Emp. + Child(ren)
___Emp. + Family

VISION PLAN

___EyeMed Essential Vision Plan
___EyeMed Enhanced Vision Plan
___No Vision Coverage
___No Changes

LEVEL OF COVERAGE

___Emp. Only
___Emp. + Spouse/Spons. Dependent
___Emp. + Child(ren)
___Emp. + Family

ADDITIONAL INFORMATION Select Add/Cancel for each individual you want to cover on each plan (Health, Dental, and/or Vision)

Name (Last, First)	Date of Birth	Social Security #	Sex M/F	Disabled Y/N	Relationship	Health Plan		Dental Plan		Vision Plan	
						Add	Cancel	Add	Cancel	Add	Cancel
SPOUSE											
DEPENDENTS											

Acknowledgement and Signature

I understand that I have made the above plan election for the plan year, and I authorize the University of Kentucky to reduce my pay accordingly. Thus, I authorize payment of premiums on a pre-tax basis. I also confirm that the dependent information I have provided is correct to the best of my knowledge. I understand that the choices I have made on this form cannot be changed until the next enrollment period unless I have a change in family status as defined by law. If I do not complete and return a new Health, Dental, and Vision Plan form during future enrollment periods, I will be treated as having elected to continue the elements of health, dental, and vision coverage then in effect if the plan is still available (whether insured or self-insured) for the new plan year. In addition, these elections will apply to any changes to the amount of the required employee contribution for the health, dental and vision plans I have elected. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

Signature	Date

Return to: UK Benefits 112 Scovell Hall Lexington, KY 40506-0064 or Fax: (859) 323-1095

We recommend you keep a copy of the completed form for your records.