Human Resources

COBRA Health, Dental and Vision Plan Enrollment Form 2025-26

Office use only
Person ID _____
Effective date _____

SUBSCRIBER INFORMATION

Last name _____ First name _____ Middle Initial _____

Person ID or Social Security number _____ Email address _____ Date of birth _____

Home address _____ City _____ State _____ Zip code _____ Home phone _____ Cell phone _____

REASON FOR APPLICATION (CHECK ONE)

- ☐ Marriage
- ☐ Birth/adoption
- ☐ Gain/loss of coverage
- ☐ Divorce
- ☐ Death
- ☐ Open enrollment for spouse
- ☐ Family judgment, decree or court order
- ☐ Dependent no longer eligible for coverage
- ☐ Name/address change
- ☐ Change in employment status:
  Separation date from UK, if applicable: _____

If you are a spouse or dependent applying for COBRA, please provide the UK employee's name, person ID or social security number: _____

HEALTH INSURANCE

- ☐ UK-HMO
- ☐ UK-PPO
- ☐ UK Indemnity
- ☐ UK Health Saver
- ☐ No coverage
- ☐ No changes

Level of coverage

- ☐ Subscriber only
- ☐ Subscriber + family
- ☐ Subscriber + children
- ☐ Employee + spouse/sponsored dependent

DENTAL INSURANCE

- ☐ UK Dental Basic
- ☐ UK Dental Comprehensive
- ☐ Delta Dental Basic
- ☐ Delta Dental Enhanced
- ☐ No coverage
- ☐ No changes

Level of coverage

- ☐ Subscriber only
- ☐ Subscriber + children
- ☐ Subscriber + family
- ☐ Subscriber + spouse/sponsored dependent

VISION INSURANCE

- ☐ EyeMed Essential
- ☐ EyeMed Enhanced
- ☐ No coverage
- ☐ No changes

Level of coverage

- ☐ Subscriber only
- ☐ Subscriber + children
- ☐ Subscriber + family
- ☐ Subscriber + spouse/sponsored dependent

CONTINUE FSA?

☐ Yes ☐ No

$ _____

COVERED SPOUSE/SPONSORED DEPENDENT							HEALTH		DENTAL		VISION	
Last name	First name	Social Security #	Date of birth	Sex	Disabled (Y/N)	Relationship	Add	Cancel	Add	Cancel	Add	Cancel

DEPENDENTS							HEALTH		DENTAL		VISION	
Last name	First name	Social Security #	Date of birth	Sex	Disabled (Y/N)	Relationship	Add	Cancel	Add	Cancel	Add	Cancel

I understand that I have made the above elections for the plan year, and I authorize the University of Kentucky to reduce my pay accordingly. 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 the enrollment periods, I will be treated as having elected to continue the elements of health, dental and vision 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 hereto, commits a fraudulent insurance act, which is a crime.

Signature _____ Date _____

Please return this form to UK HR Benefits, 106 Bosworth Hall, Lexington, KY 40506. You can also fax it to 859-323-1095 or email benefits@uky.edu.