



COBRA Health, Dental and Vision Plan Enrollment Form 2026-27

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, Divorce, Family judgment, decree or court order, Name/address change, Birth/adoption, Death, Dependent no longer eligible for coverage, Change in employment status, Gain/loss of coverage, Open enrollment for spouse, 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, DENTAL INSURANCE, VISION INSURANCE, CONTINUE FSA? (Yes/No), Level of coverage options for each insurance type.

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

DEPENDENTS table with columns: Last name, First name, Social Security #, Date of birth, Sex, Disabled (Y/N), Relationship, HEALTH (Add/Cancel), DENTAL (Add/Cancel), VISION (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...

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 hr@uky.edu.