

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

Office use only
Person ID _____
Effective date _____

EMPLOYEE INFORMATION

Last name _____ First name _____ Middle Initial _____ Status UK KCTCS
 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)

New enrollment Marriage Divorce Family judgment, decree or court order Name/address change
 Open enrollment Birth/adoption Death Dependent no longer eligible for coverage Change in employment status:
 Change of enrollment (select reason for change) Gain/loss of coverage Open enrollment for spouse Separation date from UK, if applicable: _____
 *Supporting documentation may be required

HEALTH INSURANCE <input type="checkbox"/> UK-HMO <input type="checkbox"/> UK-PPO <input type="checkbox"/> UK Indemnity <input type="checkbox"/> UK Health Saver <input type="checkbox"/> No coverage <input type="checkbox"/> No changes Level of coverage <input type="checkbox"/> Employee only <input type="checkbox"/> Employee + spouse/sponsored dependent <input type="checkbox"/> Employee + family <input type="checkbox"/> Employee + family with combined credit <input type="checkbox"/> Employee + children SSN or Person ID of spouse: _____	DENTAL INSURANCE <input type="checkbox"/> UK Dental Basic <input type="checkbox"/> No coverage <input type="checkbox"/> UK Dental Comprehensive <input type="checkbox"/> No changes <input type="checkbox"/> Delta Dental Basic <input type="checkbox"/> Delta Dental Enhanced Level of coverage <input type="checkbox"/> Employee only <input type="checkbox"/> Employee + children <input type="checkbox"/> Employee + family <input type="checkbox"/> Employee + spouse/sponsored dependent	VISION INSURANCE <input type="checkbox"/> EyeMed Essential <input type="checkbox"/> No coverage <input type="checkbox"/> EyeMed Enhanced <input type="checkbox"/> No changes Level of coverage <input type="checkbox"/> Employee only <input type="checkbox"/> Employee + children <input type="checkbox"/> Employee + family <input type="checkbox"/> Employee + spouse/sponsored dependent
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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. 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 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 _____