Human Resources

Employee Health, Dental and Vision Plan Enrollment Form 2024-25

Office use only
Person ID _____
Effective date _____

EMPLOYEE INFORMATION

Last name _____ First name _____ Middle initial _____ Status ☐ UK ☐ KCTCS ☐ CKMS ☐ ESH

Person ID or Social Security number _____ Email address _____

Home address _____

City _____ State _____ ZIP code _____ Home phone _____ Work phone _____

REASON FOR APPLICATION (CHECK ONE)

☐ New enrollment
☐ Open enrollment
☐ Change of enrollment
(Select reason for change, Supporting documentation may be required)

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

HEALTH INSURANCE (Select desired level of coverage)

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

Level of coverage

☐ Employee only
☐ Employee + family
☐ Employee +children
☐ Employee + spouse/spons. dep.
☐ Employee + family with combined credit

SSN or Person ID of spouse: _____

DENTAL INSURANCE

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

Level of coverage

☐ Employee only ☐ Employee + children
☐ Employee + family
☐ Employee + spouse/spons. dep.

VISION INSURANCE

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

Level of coverage

☐ Employee only ☐ Employee + children
☐ Employee + family
☐ Employee + spouse/spons. dep.

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 _____

Please return this form to UK HR Benefits, 204 Mandrell Hall, Lexington KY 40508. You can also fax it to 859-323-1095 or email benefits@uky.edu.