



<b>Office use only</b>	
Person ID	_____
Effective date	_____

## Life Insurance and Accidental Death & Dismemberment Insurance Enrollment Form 2023-24

### EMPLOYEE INFORMATION

Last name \_\_\_\_\_ First name \_\_\_\_\_ Middle initial \_\_\_\_\_  
 Person ID or Social Security number \_\_\_\_\_ Email address \_\_\_\_\_  
 Home phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Status  UK  KCTCS  CKMS  ESH

### REASON FOR APPLICATION (CHECK ONE)

New enrollment  Change of enrollment (select reason for change below)\*  
 Open enrollment  Marriage  Divorce  Family judgment, decree or court order  
 Birth/adoption  Death  Dependent no longer eligible for coverage  
 Change in employment status of spouse or employee  
 Separation date from UK (if applicable) \_\_\_\_\_

**\*Supporting documentation may be required**

**UK provides basic life and accidental death & dismemberment insurance equal to one times your annual salary. Please make any selections for additional coverage below.**

### OPTIONAL LIFE INSURANCE

<input type="checkbox"/> Optional life 1 times salary	<input type="checkbox"/> Optional life 4 times salary	<input type="checkbox"/> Optional life 7 times salary
<input type="checkbox"/> Optional life 2 times salary	<input type="checkbox"/> Optional life 5 times salary	<input type="checkbox"/> Optional life 8 times salary
<input type="checkbox"/> Optional life 3 times salary	<input type="checkbox"/> Optional life 6 times salary	<input type="checkbox"/> No coverage

### OPTIONAL LIFE – SPOUSE/SPONSORED DEPENDENT

\$10,000  \$25,000  
 \$15,000  \$30,000  
 \$20,000  No coverage

### OPTIONAL LIFE – CHILDREN

\$10,000  \$25,000  
 \$15,000  \$30,000  
 \$20,000  No coverage

### OPTIONAL ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Employee only  Employee + children  Employee + family  Employee + spouse  No coverage

Coverage amount (\$10,000 to \$1,000,000, in \$5,000 increments) \$ \_\_\_\_\_

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 understand that the choices I have made on this form may be reduced during the plan year, but may not be increased until the next enrollment period unless I have a change in my family status as defined by law. If an increase is requested, I understand that I may be required to complete a medical evidence of insurability questionnaire. I understand that my additional coverage will not go into effect until approved by the life insurance carrier.

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](mailto:benefits@uky.edu).**