Human Resources

Office use only
Person ID_____
Effective date_____

Life Insurance and Accidental Death & Dismemberment Insurance Enrollment Form 2024-25

EMPLOYEE INFORMATION

Last name_____ First name_____ Middle initial _____

Person ID or Social Security number_____ Email address _____

Home phone_____ Work Phone _____

Status ☐ UK ☐ KCTCS

REASON FOR APPLICATION (CHECK ONE)

☐ New enrollment
☐ Open enrollment
☐ Change of enrollment (select reason for change below)*
- ☐ 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

☐ Optional life 1 times salary
☐ Optional life 2 times salary
☐ Optional life 3 times salary
☐ Optional life 4 times salary
☐ Optional life 5 times salary
☐ Optional life 6 times salary
☐ Optional life 7 times salary
☐ Optional life 8 times salary
☐ 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.