



Office use only Person ID _____ Effective date _____

**MetLaw Enrollment
Form 2024-25**

EMPLOYEE INFORMATION

Last name _____ First name _____ Middle initial _____
 Person ID or Social Security number _____ Email address _____
 Home address _____
 City _____ State _____ ZIP code _____
 Home phone _____ Work phone _____
 Status UK KCTCS CKMS ESH

LEVEL OF COVERAGE

SINGLE FAMILY

I wish to cancel coverage

I wish to have my salary redirected for the period of July 1, 2024 , through June 30, 2025, in each of the categories listed above. I understand the benefits available to me as well as the other rights and obligations that I have under the Plan. I understand this agreement revokes any prior election under this plan and that during the above period this agreement is irrevocable and cannot be changed except under special circumstances as outlined in the Summary Plan Description. This agreement is subject to the terms of the University of Kentucky MetLaw Program.

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.**