



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

Office use only
Person ID
Effective date

RETIREE INFORMATION

Last name, First name, Middle Initial, Status, 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, Open enrollment, Change of enrollment (reason for change), \*Supporting documentation may be required

Have you been diagnosed with ESRD, ALS, If yes, please provide onset date:

HEALTH INSURANCE, DENTAL INSURANCE, VISION INSURANCE sections with various plan options and coverage levels.

Table for COVERED SPOUSE/SPONSORED DEPENDENT with columns for name, SS#, DOB, sex, disabled status, relationship, and insurance options.

Table for DEPENDENTS with columns for name, SS#, DOB, sex, disabled status, relationship, and insurance options.

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.

Signature and Date fields