



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 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, 112 Scovell Hall, Lexington KY 40506-0064. You can also fax it to 859-323-1095 or email benefits@uky.edu.