Human Resources

Office use only
Person ID _____
Effective date _____

Retiree Health, Dental and Vision Plan Enrollment Form 2024-25

RETIREE INFORMATION

Last name _____ First name _____ Middle initial _____ Status ☐ UK ☐ KCTCS

Person ID or Social Security number _____ Email address _____ Date of birth _____

Home address _____

City _____ State _____ ZIP code _____ Home phone _____ Work 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

Age 65 and older:
☐ Medicare Advantage

Under age 65:
☐ UK-HMO ☐ UK-PPO
☐ UK-RHP ☐ No coverage
☐ UK-EPO ☐ No changes

Level of coverage
☐ Retiree only
☐ Retiree + family
☐ Retiree + children
☐ Retiree + spouse/ sponsored dependent

DENTAL INSURANCE

☐ UK Dental Retiree Classic
☐ UK Dental Retiree Ultra
☐ Delta Dental Basic
☐ Delta Dental Enhanced
☐ No coverage
☐ No changes

Level of coverage
☐ Retiree only
☐ Retiree + family
☐ Retiree + children
☐ Retiree + spouse/ sponsored dependent

VISION INSURANCE

☐ EyeMed Essential
☐ EyeMed Enhanced
☐ No coverage
☐ No changes

Level of coverage
☐ Retiree only
☐ Retiree + family
☐ Retiree + children
☐ Retiree + spouse/ sponsored dependent

COVERED SPOUSE/SPONSORED DEPENDENT							HEALTH		DENTAL		VISION	
Last name	**First name**	**Social Security #**	**Date of birth**	**Sex**	**Disabled (Y/N)**	**Relationship**	**Add**	**Cancel**	**Add**	**Cancel**	**Add**	**Cancel**
							☐	☐	☐	☐	☐	☐

DEPENDENTS							HEALTH		DENTAL		VISION	
Last name	**First name**	**Social Security #**	**Date of birth**	**Sex**	**Disabled (Y/N)**	**Relationship**	**Add**	**Cancel**	**Add**	**Cancel**	**Add**	**Cancel**
							☐	☐	☐	☐	☐	☐
							☐	☐	☐	☐	☐	☐
							☐	☐	☐	☐	☐	☐
							☐	☐	☐	☐	☐	☐

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. I understand that the choices I have made on this form cannot be changed until the next enrollment period unless I have a change in family status as defined by law. If I do not complete and return a new Health, Dental and Vision Plan form during the enrollment periods, I will be treated as having elected to continue the elements of health, dental and vision plans I have elected. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material hereto, commits a fraudulent insurance act, which is a crime.

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 retirement@uky.edu.