Vision Plan Enrollment Form 2009-2010

Office Use Only	
Dependent Verified ______	Pers.No
	Eff. Date

INSURED INFORMATION Please Print or type

Last Name	First Name	MI	Person ID or Soc. Sec. #	Sex	Marital Status	Date of Birth
					☐ Single ☐ Married	

Home Address	City	State	Zip Code	Home Phone	Work Phone	Status
						☐ UK ☐ KCTCS

REASON FOR APPLICATION (CHECK ONE)

__New Enrollment
__Open Enrollment
__Name/Address Change
__Change of Enrollment (Select reason of change)**
__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

VISION PLAN

___EyeMed Vision Plan
___No Vision Coverage

LEVEL OF COVERAGE

___Emp. Only
___Emp.+Spouse/Spons. Dependent
___Emp.+Child(ren)
___Emp.+Family

ADDITIONAL INFORMATION Select Add/Cancel for each individual you want to cover on your Vision Plan

Name (Last, First)	Date of Birth	Social Security #	Sex	Student Y/N	Disabled Y/N	Relationship	Add	Cancel
SPOUSE/SPONSORED DEPENDENT								
DEPENDENTS								

Are you or anyone listed above covered by another Group Vision Plan? If so, you must complete the following:

Name (Last, First)	Name and Address of Insurance Company	Coverage Level	Effective Date	Policy #

Acknowledgement and Signature

I understand that I have made the above plan election for the plan year, and I authorize the University of Kentucky to reduce my pay accordingly. Thus, I authorize payment of premiums according to IRS guidelines. 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 Vision Plan form during future enrollment periods, I will be treated as having elected to continue the elements of vision coverage then in effect if the plan is still available (whether insured or self-insured) for the new plan year. In addition, these elections will apply to any changes to the amount of the required employee contribution for the 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 thereto, commits a fraudulent insurance act, which is a crime.

Signature	Date

Return To:	Employee Benefits Office 112 Scovell Hall Lexington, KY 40506-0064

We recommend you keep a copy of the completed form for your records.