



**COBRA: Vision Plan
Enrollment Form
2009-2010**

Office Use Only
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
					<input type="checkbox"/> Single <input type="checkbox"/> Married	
Home Address	City	State	Zip Code	Home Phone	Work Phone	Status
						<input type="checkbox"/> UK <input type="checkbox"/> KCTCS

REASON FOR APPLICATION (CHECK ONE)	VISION PLAN	LEVEL OF COVERAGE
<input type="checkbox"/> New Enrollment <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Name/Address Change <input type="checkbox"/> Change of Enrollment (Select reason of change)** <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Family judgment, decree or court order <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Death <input type="checkbox"/> Dependent no longer eligible for coverage <input type="checkbox"/> Change in employment status of spouse or employee: Separation date from UK (if applicable): _____ **Supporting documentation may be required	<input type="checkbox"/> EyeMed Vision Plan <input type="checkbox"/> No Vision Coverage	<input type="checkbox"/> Emp. Only <input type="checkbox"/> Emp.+Spouse/Spons. Dependent <input type="checkbox"/> Emp.+Child(ren) <input type="checkbox"/> 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 have read and understand the materials I have been given about my rights to continue group health, dental and vision coverage for myself and, if applicable, my eligible dependents. I understand that enrollment in any other health, dental and vision coverage plan which is provided through an employer will make me ineligible for continuation of coverage under this election. By electing to continue coverage, I understand that I must submit premium payments to the University of Kentucky by the 29th of the month for coverage the following month and that the first premium payment is due 45 days after initial election. I understand the premium amount is subject to change. I also understand that my coverage will be cancelled if these payments are not made in accordance with the COBRA regulations and, once cancelled, this coverage will not be reinstated. I confirm that the dependent information I have provided is correct to the best of my knowledge. If I do not complete and return a new COBRA Benefits Enrollment form during open enrollment periods, I will be treated as having elected to continue the elements of health, dental and/or vision coverage then in effect if the plan is still available (whether insured or self-funded) for the new plan year as long as I am still within my continuation period.

Signature	Date