



Health Plan Enrollment Form 2009-10

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 <input type="checkbox"/> Single <input type="checkbox"/> Married	Date of Birth
Home Address	City	State	Zip Code	Home Phone	Work Phone	Status <input type="checkbox"/> UK <input type="checkbox"/> KCTCS

REASON FOR APPLICATION (CHECK ONE)	HEALTH 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): _____	<input type="checkbox"/> UK-HMO (Lexington Service Area) <input type="checkbox"/> UK-HMO (Regional Service Area) <input type="checkbox"/> UK-PPO <input type="checkbox"/> UK-EPO <input type="checkbox"/> UK Indemnity <input type="checkbox"/> No Health Coverage	<input type="checkbox"/> Emp. Only <input type="checkbox"/> Emp.+Spouse/Spons. Dependent <input type="checkbox"/> Emp.+Child(ren) <input type="checkbox"/> Emp.+Family <input type="checkbox"/> Emp.+Family with/Combined Credit** **UK ID or Soc. Sec # of Spouse/ Spons. Dependent: _____

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

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

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DEPENDENTS

Are you or anyone listed above covered by another Group Health 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 Health Plan form during future enrollment periods, I will be treated as having elected to continue the elements of health 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 health plan 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
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