Life Insurance and AD&D Enrollment Form 2009-10

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
					☐ Single ☐ Married	

Home Address	City	State	Zip Code	Home Phone	Work Phone

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*

Basic Life Insurance

___Basic Life Only (UK Provides 1 x Salary)

Optional Life Insurance**

___Optional Life = 1 x Salary ___Optional Life = 2 x Salary
___Optional Life = 3 x Salary ___Optional Life = 4 x Salary
___Optional Life = 5 x Salary
** *In addition to* UK-provided 1x salary

Dependent Life Insurance

Optional Life Spouse/Spons. Depend.
___$5,000 Spouse/Spons. Depend.
___$10,000 Spouse/Spons. Depend.

Optional Life Dependents
___$5,000 Child(ren)/Spons. Depend.
___$10,000 Child(ren)/Spons. Depend.

					Optional Life Spouse/Depend.		Optional Life Dependents	
Name (Last, First)	Date of Birth	Social Security #	Sex	Relationship	Add	Cancel	Add	Cancel
COVERED SPOUSE/SPONSORED DEPENDENT								
COVERED DEPENDENT								

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE PLAN (CHECK ONE)

		Indicate coverage amount ($10,000 to $375,000 in $5,000 increments)
	Employee only AD&D Coverage	
	Employee and Family AD&D Coverage	$
	No AD&D Coverage	

EMPLOYEE INSURANCE BENEFICIARY(IES)

Full Name	Date of Birth	Address	Social Security #	Relationship	Check	
Primary Beneficiary(ies)		**CHANGE IN BENEFICIARY(IES) YES ☐ NO ☐**			**AD&D**	**LIFE**
Secondary Beneficiary(ies)		**CHANGE IN BENEFICIARY(IES) YES ☐ NO ☐**				

Acknowledgement of Authorization: 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 if I so choose, but may not be increased until the next enrollment period unless I have a change in 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. I hereby designate the above person(s) as my beneficiary(ies) to receive any benefit which may become due at or after my death according to the terms of the Life Insurance and AD&D Insurance plans. I reserve the right to change this Beneficiary Designation with the understanding that this designation and any change thereof, will be effective only upon delivery to the Employee Benefits Office.

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.