



**Retiree, Spouse and/or Dependent Health Plan
Enrollment Form
2009-2010**

**For Members
Under Age 65**

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

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): _____ **Supporting documentation may be required	<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"/> Pre-65 Retiree/Spouse Only <input type="checkbox"/> Pre-65 Retiree + Spouse <input type="checkbox"/> Pre-65 Retiree + Child(ren) <input type="checkbox"/> Pre-65 Retiree + Family <input type="checkbox"/> Pre-65 Retiree Spouse <input type="checkbox"/> Pre-65 Surviving Spouse

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	Disabled Y/N	Relationship	Add	Cancel
SPOUSE							

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. I 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 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 personal records.

**This form to be completed
by or for:**

- **Retiree under age 65
and/or**
- **Retiree spouse under age 65
and/or**
- **Eligible dependent(s)
of retirees**

**to add, cancel or change
health plan coverage.**

Please note:

If you are age 65 or over and retired,
you should complete a separate
“Humana Medicare Advantage Plan”
form (not the attached form) if you
wish to:

- Add coverage upon retiring or
turning 65
- Add a spouse age 65 or over to
your plan

(You will need to submit a copy of
your Medicare card with both Parts
A & B effective dates listed.) You may
request a Medicare Advantage form
from Employee Benefits by calling
(859) 257-9519, press option 3 or
1-800-999-2813, press option 3.

Note: If you are retired (at any age)
and return to work at the University
of Kentucky in a temporary position
that is at least 20% full-time (8 hours/
week), you should complete the health
plan form for active employees, NOT
the attached form.