

**Health, Dental, and Vision Plan
Enrollment Form
2006-2007**

Office Use Only
Pers.No
Eff. Date

EMPLOYEE INFORMATION Please Print or type

Last Name	First Name	MI	Social Security	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 <input type="checkbox"/> Retired

REASON FOR APPLICATION (CHECK ONE)	HEALTH PLAN	DENTAL PLAN	VISION PLAN
<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"/> Birth/Adoption <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Change in employment status of spouse or emp. <input type="checkbox"/> Dependent no longer eligible for coverage <input type="checkbox"/> Open Enrollment for Spouse <input type="checkbox"/> Family judgment, decree or court order ** 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 (Administered by Humana) <input type="checkbox"/> UK-PPO High (Administered by Humana) <input type="checkbox"/> UK-Health First (Administered by Humana) <input type="checkbox"/> UK-EPO (Administered by Humana) <input type="checkbox"/> UK Indemnity (Administered by Humana) <input type="checkbox"/> No Health Coverage	<input type="checkbox"/> MetLife Co-Pay <input type="checkbox"/> MetLife Basic <input type="checkbox"/> MetLife Enhanced <input type="checkbox"/> UK Dental Care Basic <input type="checkbox"/> UK Dental Care Comprehensive <input type="checkbox"/> UK Dental Care Retiree Ultra <input type="checkbox"/> UK Dental Care Retiree Classic <input type="checkbox"/> No Dental Coverage	<input type="checkbox"/> EyeMed Vision Plan <input type="checkbox"/> No Vision Coverage

County Residence:	LEVEL OF COVERAGE	LEVEL OF COVERAGE	LEVEL OF COVERAGE
County Employment:	<input type="checkbox"/> Emp. Only <input type="checkbox"/> Emp. + Child(ren) <input type="checkbox"/> Emp. + Family with/ Combined Credit** **Social Security # of Spouse: _____	<input type="checkbox"/> Emp. Only <input type="checkbox"/> Emp. + Spouse <input type="checkbox"/> Emp. + Child(ren) <input type="checkbox"/> Emp. + Family	<input type="checkbox"/> Emp. Only <input type="checkbox"/> Emp. + Spouse <input type="checkbox"/> Emp. + Child(ren) <input type="checkbox"/> Emp. + Family

ADDITIONAL INFORMATION Select Add/Cancel for each individual you want to cover on each plan (Health, Dental, and/or Vision)

Name (Last, First)	Date of Birth	Social Security #	Sex	Disabled Y/N	Relationship	Health Plan		Dental Plan		Vision Plan	
						Add	Cancel	Add	Cancel	Add	Cancel

SPOUSE

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DEPENDENTS

Are you or anyone listed above covered by another Group Health Plan, Dental Plan or 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 on a pre-tax basis. 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, Dental, and Vision Plan form during future enrollment periods, I will be treated as having elected to continue the elements of health, dental, and 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 health, dental and 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