



Retiree Health, Dental and Vision Plan Enrollment Form 2021-22

Office use only	
Person ID _____	_____
Effective date _____	_____

RETIREE INFORMATION

Last name _____ First name _____ Middle initial _____ Status UK KCTCS
 Person ID or Social Security number _____ Email address _____ Date of birth _____
 Home address _____
 City _____ State _____ ZIP code _____ Home phone _____ Work phone _____

REASON FOR APPLICATION (CHECK ONE)

New enrollment Change of enrollment (reason for change)* _____
 Open enrollment *Supporting documentation may be required

Have you been diagnosed with ESRD ALS If yes, please provide onset date: _____

<p>HEALTH INSURANCE</p> <p>Age 65 and older: <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> UK-HMO <input type="checkbox"/> UK-RHP <input type="checkbox"/> UK-EPO <input type="checkbox"/> UK-PPO <input type="checkbox"/> No coverage <input type="checkbox"/> No changes</p> <p>Level of coverage <input type="checkbox"/> Retiree only <input type="checkbox"/> Retiree + spouse/ <input type="checkbox"/> Retiree + family sponsored dependent <input type="checkbox"/> Retiree + children</p>	<p>DENTAL INSURANCE</p> <p><input type="checkbox"/> UK Dental Retiree Classic <input type="checkbox"/> No coverage <input type="checkbox"/> UK Dental Retiree Ultra <input type="checkbox"/> No changes <input type="checkbox"/> Delta Dental Basic <input type="checkbox"/> Delta Dental Enhanced</p> <p>Level of coverage <input type="checkbox"/> Retiree only <input type="checkbox"/> Retiree + spouse/ <input type="checkbox"/> Retiree + family sponsored dependent <input type="checkbox"/> Retiree + children</p>	<p>VISION INSURANCE</p> <p><input type="checkbox"/> EyeMed Essential <input type="checkbox"/> No coverage <input type="checkbox"/> EyeMed Enhanced <input type="checkbox"/> No changes</p> <p>Level of coverage <input type="checkbox"/> Retiree only <input type="checkbox"/> Retiree + spouse/ <input type="checkbox"/> Retiree + family sponsored dependent <input type="checkbox"/> Retiree + children</p>										
COVERED SPOUSE/SPONSORED DEPENDENT							HEALTH	DENTAL		VISION		
Last name	First name	Social Security #	Date of birth	Sex	Disabled (Y/N)	Relationship	Add	Cancel	Add	Cancel	Add	Cancel
DEPENDENTS							HEALTH	DENTAL		VISION		
Last name	First name	Social Security #	Date of birth	Sex	Disabled (Y/N)	Relationship	Add	Cancel	Add	Cancel	Add	Cancel

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. 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 the enrollment periods, I will be treated as having elected to continue the elements of 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 hereto, commits a fraudulent insurance act, which is a crime.

Signature _____ Date _____