

Human Resources					Dental and Vision t Form 2025-26					Office use Person ID_ Effective da	-	
EMPLOYEE INFORMATION												
Last name		_First name				Middle Initial		State	us 🛛 UK	Пкстс	S	
Person ID or Social Security number					Date	e of birth						
Home address		City			State Zip co	de H	Home phone		Cell phone			
REASON FOR APPLICATION (CHEC	CK ONE)											
 New enrollment Open enrollment Change of enrollment (select rease *Supporting documentation may 	Marriage Birth/adoption on for change) / be required	Divorce Death Gain/loss of co)ependen	gment, decree or court order t no longer eligible for coverage llment for spouse	Chan	e/address chang ge in employme on date from Uł	ent status				
HEALTH INSURANCE	•	DENTAL IN	SURANCE			VISIO	N INSURANCE					
UK-HMO UK-PPO UK Indemnity UK Health Saver No coverage No changes		UK Dent UK Dent Delta De					No coverage No changes					
Employee + family	Employee + spouse/sponsored depe Employee + family with combined cre N or Person ID of spouse:	vith combined credit Employee only			Employee + children Employee + spouse/sponsored	Level of coverage Employee only Employee + family dependent			Employee + children Employee + spouse/sponso			
COVERED SPOUSE/SPONSORED	DEPENDENT	_					HEALT	Ή	DEN	NTAL	, I I I I I I I I I I I I I I I I I I I	VISI
Last name	First name	Social Security #	Date of birth	Sex	Disabled (Y/N) Relationship		Add Ca	ancel	Add	Cancel	Add	
DEPENDENTS Last name	First name	Social Security #	Date of birth	Sex	Disabled (Y/N) Relationship		Add C	ancel		VTAL Cancel	Add	VISIO
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I understand that I have made the above el	ections for the plan year, and I authorize th	e University of Kentuc	ky to reduce my p	bay accordi	ngly. Thus, I authorize payment of premi	ums on a pre-tax ba	asis. I also confirm	n that the c	dependent info	 ormation I ha	ave provided	is co

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Last name	_First name					Middle Initial		Sta	itus 🛛 UK	Пкстс	S		
Person ID or Social Security number	Email address							_ Dat	te of birth				
Home address	City Zi				te Zip code	e H	Home phone Cell				l phone		
REASON FOR APPLICATION (CHECK ONE)													
 New enrollment Open enrollment Change of enrollment (select reason for change) *Supporting documentation may be required 	Divorce Death Gain/loss of co	De	imily judgment, ependent no lor pen enrollment	nger eligib	le for coverage			hange syment statu m UK, if app					
HEALTH INSURANCE UK-HMO UK-PPO UK Health Saver No coverage UK Health Saver No coverage	DENTAL INSURANCE UK Dental Basic No coverage UK Dental Comprehensive No changes Delta Dental Basic Delta Dental Enhanced									No coverage No changes			
Level of coverage Employee only Employee + spouse/sponsored dependence Employee + family Employee + family with combined creed Employee + children SSN or Person ID of spouse:	endent Level of coverage					Level of coverage Employee only Employee + family dependent			Employee + children Employee + spouse/sponsored			ored	
COVERED SPOUSE/SPONSORED DEPENDENT	-						HE	ALTH	DE	NTAL		VISI	
Last name First name	Social Security #	Date of birth	Sex Disab	oled (Y/N)	Relationship		Add	Cancel	Add	Cancel	Add		
DEPENDENTS							н	EALTH	DF	NTAL		VISIO	
Last name First name	Social Security #	Date of birth	Sex Disat	bled (Y/N)	Relationship		Add	Cancel	Add	Cancel	Add		
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I understand that I have made the above elections for the plan year, and I authorize the	 e University of Kentud	 cky to reduce my pa	 ay accordingly. Th	us, I author	rize payment of premium	is on a pre-tax ba	 asis. I also co	 Infirm that the	dependent inf	ormation I ha	ve provided	l is co	

Human Resources					, Dental and V nt Form 2025-2						Office use Person ID Effective d		
EMPLOYEE INFORMATION													
Last name		_First name					Middle Initial		Sta	tus 🛛 UK	Пкста	CS	
Person ID or Social Security number		Email address							_ Dat	e of birth			
Home address		City	/	State Zip coc			de H	e	Cell phone				
REASON FOR APPLICATION (CHEC	CK ONE)												
 New enrollment Open enrollment Change of enrollment (select rease *Supporting documentation may 		Divorce Death Gain/loss of co)epender	lgment, decree or nt no longer eligik ollment for spous	le for coverage	Chan		change byment statu m UK, if appl				
HEALTH INSURANCE UK-HMO UK-PPO UK Health Saver No coverage No changes		DENTAL IN UK Dent UK Dent Delta De Delta De	VISION INSURANCE EyeMed Essential EyeMed Enhanced			☐ No coverage ☐ No changes							
Level of coverage Employee only Employee + family Employee + children	bendent Level of coverage aredit Employee only Employee + family dependent					Em Em	Level of coverage Employee only Employee + family dependent			Employee + children Employee + spouse/sponsored			
COVERED SPOUSE/SPONSORED	DEPENDENT						I	H	EALTH	DE	NTAL		VISI
Last name	First name	Social Security #	Date of birth	Sex	Disabled (Y/N)	Relationship		Add	Cancel	Add	Cancel	Add	
DEPENDENTS								H	EALTH	DE	NTAL		VISIC
Last name	First name	Social Security #	Date of birth	Sex	Disabled (Y/N)	Relationship		Add	Cancel	Add	Cancel	Add	
I understand that I have made the above el	ections for the plan year, and I authorize th	 e University of Kentuc	 ky to reduce my r	 Day accord	 lingly. Thus, I autho	 ize payment of premiu	ıms on a pre-tax ba	 asis. I also co	 onfirm that the	dependent inf	 ormation I ha	ve provided	is co

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 then in effect if the plan is still available (whether 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 hereto, commits a fraudulent insurance act, which is a crime.

Signature __

Date 🗕

