Please Check One

☐ UK ☐ CKMS ☐ ESH ☐ KCTCS

UniCare
An Anthem Company

Employee Enrollment Form
Voluntary Long Term Disability

SECTION I - EMPLOYEE INFORMATION

This enrollment form is for actively at work regular F.T. employees covered by the University's base LTD Plan.

Name	Employee ID (paystub)	Date of Hire	Wage (Monthly Salary)	Gender (M or F)

Date of Birth	Municipality	Effective Date	Job Title
	002	TBD	

Home Address (Number and Street)	City	State	Zip Code

SECTION II - BENEFIT SELECTION - Check the box that applies:

Voluntary Long Term Disability

Voluntary Long term disability insurance helps to replace your income if you are sick or injured and cannot work. This coverage begins after you have been disabled for 180 days (elimination period). The plan provides income protection to replace up to 10% of your Base Salary to a maximum of $9,120 per month. Please use the provided LTD Buy-Up Worksheet to calculate your monthly benefit and premium. Salary information can be obtained from the Benefits Office.

ACCEPT	***DECLINE***	***Benefit Amount***	****Premium***
☐	☐	_____ **/Month**	_____ **/Month**

SECTION III - ACCEPTANCE AND ACKNOWLEDGEMENT

Decline Supplemental /Voluntary Coverage

My signature below certifies that I have been given the opportunity to participate in the University of Kentucky's Voluntary Long Term Disability benefit program. The benefits have been clearly explained to me. After careful consideration I have decided not to participate in the benefits listed above where I have checked "decline". I understand that if I later decide to apply for coverage under this plan I may be required to furnish evidence of insurability.

_____ _____

I, , DECLINE Coverage **Date**

Accept and Acknowledge Coverage

I acknowledge that the information I have provided is accurate to the best of my knowledge. I AUTHORIZE the University of Kentucky to obtain, use and disclose Individual Claims and Participant Information including claims history. The information identified above will be shared only for the purpose of adding benefits to, renewing, replacing or amending coverage under the University's Group Plan. The following persons are authorized to make the requested uses and disclosures of the information identified herein: Your Group Plan, its administrator, the insurance agents or brokers or any other person or entity performing functions on behalf of Your Group Plan. The information identified herein will be disclosed only to Your Group Plan, its administrator, insurance agents or brokers or any other person or entity performing functions on behalf of Your Group Plan, and insurance carriers from which Your Group Health plan requests potential coverage or a quote for such coverage. This agreement shall expire at the termination of your employment with the University. However, you retain the right to revoke this authorization before that date in writing by contacting your Benefits Department. Your refusal to sign this document or subsequent revocation of this signed authorization may be used as the basis for denying your treatment, payment, enrollment or eligibility for benefits. Information disclosed under authorization is subject to re-disclosure by the recipient; however, any information disclosed to health care providers, insurance companies, insurance agents and brokers, health plans and health plan administrators, will continue to be protected and not be reused or re-disclosed other than as authorized by you or permitted by law. I have read and understand the information above and with my signature below authorize the receipt, use and disclosure of the information described in this document for the limited purposes identified herein. No promises or representations have been made to me to induce me to sign this form. I AUTHORIZE **the University of Kentucky** to make payroll deductions for the above specified coverage and release other necessary information to the administrators of this program. *The premium will increase automatically based on age and subsequent salary changes.

X _____

Signature **Date**

UNIVERSITY OF KENTUCKY
Voluntary Long-term Disability Insurance Application
(To be used within 60 days of eligibility)

Please return this form to:

The MPM Group
1010 Monarch St., Suite 220
Lexington, KY 40513

or

Email: jbaylon@thempmgroupllc.com