☐ *UK* ☐ *KCTCS* ☐ *CKMS*
Please Check One

UniCare
A WellPoint 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		

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 b 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.

_____ _____

Signature **Date**

UNICARE.

Personal Health Statement

Section I – To be completed by Policyholder

POLICY / PLAN #: 145483 POLICYHOLDER (EMPLOYER): University of Kentucky

Section II – To be completed by Employee

Employee Name: _____ Date of Birth: _____ Sex: ☐ M ☐ F

Employee Address: _____ Date of Hire: _____ Late Applicant: ☐ Yes ☐ No

When and for what did you last consult a physician? Give date, name and address of physician or practitioner, and nature of injury or illness.

Please answer the following questions. If any part is answered "Yes" give particulars and dates in the space provided to the right of the form.

1.		Do you have any disease or ailment at the present time?	☐ Yes ☐ No
2.		If the answer to #1 is "Yes", do you contemplate or has a physician recommended an operation or any medical treatment for this condition?	☐ Yes ☐ No
3.		During the past five years have you…	
	A.	Had any disease of the Kidneys?	☐ Yes ☐ No
	B.	Been advised that you have Diabetes? (If "Yes", provide Type, Medication and Dosage)	☐ Yes ☐ No
	C.	Had any disease of the Heart?	☐ Yes ☐ No
	D.	Been advised that you have Abnormal Blood Pressure? (If "Yes", provide two readings and medications)	☐ Yes ☐ No
	E.	Had any disease of the Stomach or Bowel?	☐ Yes ☐ No
	F.	Had any disease of the Immune System?	☐ Yes ☐ No
	G.	Had any disease of the Lungs?	☐ Yes ☐ No
	H.	Had any disease of the Neurological System?	☐ Yes ☐ No
	I.	Had any disease of the Genital or Urinary Tract?	☐ Yes ☐ No
	J.	Had any disease of the Musculo-Skeletal System?	☐ Yes ☐ No
	K.	Had advice, attendance or treatment by a physician, practitioner or any other person? (Give dates and reason)	☐ Yes ☐ No
	L.	Had treatment or observation in a clinic, hospital or residential treatment program? (Give dates and reason)	☐ Yes ☐ No
4.	A.	Have you ever applied for Life, Health or Accident coverage and been declined, postponed or restricted, or has a policy been issued and afterwards cancelled?	☐ Yes ☐ No
	B.	Have you ever received any insurance benefits or compensation of any kind for illness or injury?	☐ Yes ☐ No

5. What is your height _____ feet _____ inches, weight _____ pounds?

6. Are you pregnant? ☐ Yes ☐ No

7. Requested Coverage Type and Amount

☐ Basic Life Insurance	Current Amount: $	Requested Amount: $ N/A
☐ Supplemental Life Insurance	Current Amount: $	Requested Amount: $ N/A
☐ Voluntary Life Insurance	Current Amount: $	Requested Amount: $ N/A
☐ Short Term Disability	Current Amount: $	Requested Amount: $ N/A
☐ Long Term Disability	Current Amount: $	Requested Amount: $

To the best of my knowledge and belief, the foregoing statements and answers, e ach of which I have made and read, are complete and true, are correctly and fully recorded, and no material circumstances or information concerning my past and present state of health has been omitted or withheld. I hereby declare that a duplicate copy of this instrument containing the above statements or answers together with any explanations there to has been furnished to me by the insurance company.

SIGNATURE OF THE EMPLOYEE: _____ DATE: _____

PLEASE READ AND SIGN THE REVERSE SIDE OF THIS FORM

DISCLOSURE AUTHORIZATION

PERMISSION TO OBTAIN INFORMATION

I hereby authorize any licensed physician, medical practitioner, clinic, hospital or other medical or medically related facility, insurance company, consumer reporting agency, or employer, or any other similar person, institution, or organization to give the UniCare Life & Health Insurance Company ("The Company") any and all information and copies of records relating to the proposed applicant named on this form and any proposed covered dependents.

TYPES OF INFORMATION REQUIRED

The information requested may include all information available as to diagnosis and treatment with respect to any physical or mental condition.

USE AND DISCLOSURE

The information collection under this authorization will be used for determining your eligibility and your proposed covered dependent's eligibility. All or part of the information may be used to determine eligibility for benefits under any policy or benefit program administered by the company and for other business purposes in connection with the insurance relationship. It may also be sent to any reinsurance company with which The Company does business and any other organization which performs services in connection with the insurance relationship. In addition, your employer may have access to your answers to the questions on the attached Personal Health Statement. It is understood that the company will obtain permission from the undersigned before any of the information collected is disclosed to any person or organization other than as specified in or implied by this authorization.

COPY OF AUTHORIZATION

I understand that I may request a copy of this authorization. I agree that a photocopy of this authorization may be used to obtain information.

EFFECTIVE DATE

This authorization shall remain valid for thirty months after the date of signing.

Name of Proposed Applicant: _____

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, of conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and, with respect to New York State residents only; will also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Employee Signature: _____ Date: _____

Return this form to:

Life Underwriting Unit
P.O. Box 4510
Woodland Hills, CA 91365