

Service Request Form



To be used by University of Kentucky employees for SLD Universal Life, Trustmark Short-Term Disability, Trustmark Accident, Aflac Critical Illness, Aflac Short-term Disability, and Aflac Accident.

Employee Information

Name _____ SSN _____ Date of Birth _____
 Street Address _____ City _____ State _____ Zip _____
 Home Phone _____ Cell Phone _____ Email _____

Service Type

Name Change:

New Name _____ (Please provide proof of change)

Change of Address:

New Street Address _____ City _____ State _____ Zip _____

Type of Coverage	Insurance Company	Policy Number

Direct Bill Reason for Request: _____

Coverage to be Direct Billed	Insurance Company	Policy Number

Cancellation Reason for Cancellation: _____

Coverage to be Cancelled	Insurance Company	Policy Number

Reason for Direct Bill or Cancellation Request:

Marriage
 Birth/Adoption
 Divorce
 Death
 Dependent no longer eligible
 Family judgment, decree, or court order
 Open Enrollment for Spouse
 Change in employment status of spouse or employee: **Separation date from UK (if applicable)** _____

Please note that Direct Bill Requests and Cancellation Requests can only be made during Open Enrollment for Short-Term Disability, Cancer, and Accident Plans unless you have a "qualifying event". Supporting documentation will be required.

Employee Signature _____ **Date** _____

Policy Owner Signature _____ **Date** _____

(If different than employee)

For MPM Office Use Only	
These Changes are being requested during the employees' normal open enrollment:	<input type="checkbox"/> Yes <input type="checkbox"/> No
These changes are being made due to a qualifying event:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Effective Date for Change(s): _____/_____/_____	MPM Employee ID _____