University of Louisville
SUPPLEMENTAL BENEFITS CHANGE AND SERVICE REQUEST FORM

Name: ______________________________ Employee ID: ________________ Social Security Number: _____________

Current Street Address: ____

City: ____ State: ____________ Zip Code: ________________

☐ **Check if this is an Address Change** **Pay Frequency:** ☐ Monthly ☐ Biweekly

Phone Number: ( ) ________________________ Email Address: ________________________________

STEP 1: Indicate The Coverage You Currently Have	☐ **Short Term Disability** ☐ **Cancer** ☐ **Critical Illness** ☐ **Legal Services**

STEP 2: Please complete the appropriate section(s) below.

☐ **Policy Cancellation**

I request cancellation of (check all that apply):

☐ **Short Term Disability** ☐ **Cancer** ☐ **Critical Illness** ☐ **Legal Services**

I authorize the University of Louisville and Fringe Benefits Management Company to stop the deductions for this coverage accordingly. I understand that any premium deductions following my cancellation request that are remitted to the provider will be refunded to me directly by the provider. I further understand that once this benefit has been cancelled I may reapply for this benefit and any other benefits offered by the provider during my employer's next supplemental benefits enrollment period. I further understand that applications taken at a future date may require me to provide proof of eligibility, in which additional underwriting may be required for policy issuance by the provider.

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Insured's Signature (REQUIRED)

☐ **Request Policy Reduction**

Benefit	**Policy/Certificate #**	**Reduce Amount of Insurance**	
		From	**To**
☐ **Short Term Disability**			
☐ **Critical Illness**			
☐ **Cancer**			

☐ **Request for Duplicate Policy or Certificate**

I hereby declare that my certificate/policy was lost or destroyed under the following circumstances:

By signing below, I represent that the statements and answers given on this application, to the best of my knowledge are true, complete and correctly recorded.

STEP 3: Required Signature

Signature: ____ Date ______________________

STEP 4: Delivery Of Completed Form

Mail or deliver the completed form to:

University of Louisville
Human Resources ATTN: HR Help Desk
1980 Arthur Street
Louisville, KY 40208-2730.

For questions, please email the UofL Benefits Service Account at Benefits@louisville.edu or call (502) 852-6258 and ask to speak to an HR Help Desk Representative.