



■ HUMAN RESOURCES  
DEPARTMENT

University of Louisville  
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Louisville, Kentucky 40208  
502-852-6258  
Fax: 502-852-5665  
Email: hrhelp@louisville.edu  
www.louisville.edu/admin/humanr

TO: ALL RESIDENTS  
FROM: HUMAN RESOURCES  
DATE: March 20, 2008  
RE: BENEFIT FORMS

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The following two forms should be turned in by everyone.

1. **University of Louisville Health Plan 2008**; you will either be choosing a health plan or providing the name and policy number of your other coverage outside of the university.
2. **Sun Life Assurance company of Canada- Beneficiary Designation**; this is how you designate who would receive the proceeds of your UofL paid life insurance in the event of your death.

All other forms are optional.

***Flexible Spending Account***- may be either your own money or \*waiver money.

\*If you waive health insurance and would like to use some of your waiver money for dependant care you must fill out this form accordingly.

***Sun Life Optional Life Enrollment Form***- if you would like more than the UofL paid amount

***Anthem Dental***

***Anthem Vision***

***Affidavit for Qualifying Adult for Benefit Coverage***; only necessary if adding a qualifying adult to your benefits.

Please see the Human Resources representatives at Orientation June 30 or call 852-6258 for assistance.

# 2008 UNIVERSITY OF LOUISVILLE HEALTH PLAN

PLEASE PRINT Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  Male  Female  Single  Married

Street Address \_\_\_\_\_ Apartment Number \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_ Employee I.D. \_\_\_\_\_ Pay Basis, Biweekly or Monthly \_\_\_\_\_

New employee Date of hire is: \_\_\_\_\_  Retire  
 I'm on a 10-month contract

**Qualifying event and need to make a change in my coverage (attach support documentation).** Effective date \_\_\_\_\_  
 Marriage  Birth/adoption  Spouse/dependent has other coverage  Loss of eligibility  Divorce  Spouse deceased  Spouse/dependent's coverage ends

### Choose One Plan Type:

- PCA High**
- PCA High Employee Only
  - PCA High Employee & Spouse
  - PCA High Employee & Dependents
  - PCA High Employee & Family
  - PCA High Two Employee Family

- PCA Low**
- PCA Low Employee Only
  - PCA Low Employee & Spouse
  - PCA Low Employee & Dependents
  - PCA Low Employee & Family
  - PCA Low Two Employee Family

- PPO**
- PPO Employee Only
  - PPO Employee & Spouse
  - PPO Employee & Dependents
  - PPO Employee & Family
  - PPO Two Employee Family

- EPO**
- EPO Employee Only
  - EPO Employee & Spouse
  - EPO Employee & Dependents
  - EPO Employee & Family
  - EPO Two Employee Family

- NNP**
- NNP Employee Only
  - NNP Employee & Spouse
  - NNP Employee & Dependents
  - NNP Employee & Family
  - NNP Two Employee Family

### Spouse/Dependent Information:

Spouse  add  change  delete Effective Date \_\_\_\_\_  Male  Female

Social Security Number \_\_\_\_\_ Date of marriage \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Date of Birth \_\_\_\_\_

Dependent  add  change  delete Effective Date \_\_\_\_\_

Social Security Number \_\_\_\_\_  Male  Female

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Date of Birth \_\_\_\_\_

Dependent  add  change  delete Effective Date \_\_\_\_\_

Social Security Number \_\_\_\_\_  Male  Female

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Date of Birth \_\_\_\_\_

Dependent  add  change  delete Effective Date \_\_\_\_\_

Social Security Number \_\_\_\_\_  Male  Female

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Date of Birth \_\_\_\_\_

### Authorization and Signature (only sign if accepting university coverage)

I hereby acknowledge I have read the statements in this application, or they have been read to me, and the statements are true and complete to the best of my knowledge and belief and together with any supplements thereto, shall be the basis for any certificate of coverage/certificate of insurance issued. I understand any intentional misrepresentation contained herein may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation affects acceptance of the risk.

I understand and agree that neither the employer nor the agent has the authority to waive a complete answer to any questions, pass on coverage or insurability, alter any contract, or waive any of the company's other rights or requirements. I hereby enroll for benefits for which I am presently eligible, or for which I may become eligible, under my employer's group contract(s). I authorize deductions for this coverage from my earnings if any such deductions for this coverage are required. Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a claim or application containing any false, incomplete or misleading information could be chargeable with a felony. I hereby agree that no coverage is effective until the date specified by the company after this application has been accepted.

Authorization: I authorize any physician, medical practitioner, hospital, clinic, veterans administration facility, other medical or medically-related facility, insurance, HMO or reinsuring company, the Medical Information Bureau, Inc., Consumer Reporting Agency having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my covered dependents, and any other non-medical information of me or my covered dependents to share with Humana or their legal representative any and all such information.

I understand this information obtained by use of the authorization may be used by Humana to determine eligibility for coverage and eligibility of benefits under an existing policy and plan administration, including quality assurance, medical management, case management, coordination of benefits, subrogation and health promotion/disease management. Any information obtained will not be released by the insurer or health maintenance organization to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my application, claim or as may be otherwise lawfully required, or as I may further authorize. I know that I may request a copy of this authorization. I agree that a photographic copy of this authorization shall be as valid as the original. I agree that this authorization shall be valid for one (1) year from the date the authorization is signed.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

### Waiver of Medical Coverage

You must complete the section below only if you are waiving (declining) any of the coverage available to you through your employer. **This is to acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents pursuant to state law through the above named employer.** I proclaim that I was not pressured or forced by my employer, the writing agent, or Humana into waiving (declining) the above noted coverage. I understand that Humana reserves the right to deny coverage in any future application for coverage and that any subsequent application shall be subject to the application terms and conditions of the master group contract(s) which may require additional limitations and waiting periods. I also understand that I may be required to furnish to Humana, at my expense, evidence of health status which will be used only for rating purposes and not to determine my eligibility to enroll in a Humana plan. I freely and voluntarily waive the above coverage. If you are declining health enrollment for yourself and your dependents (including your spouse) because of other medical coverage, you may in the future be able to enroll yourself and your dependents in the health plan, provided that you request enrollment within 30 days or as mandated by state legislation after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days of the marriage, birth, adoption or placement for adoption.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

# Sun Life Assurance Company of Canada

## Beneficiary Designation



You may use this form to designate who will receive the Group Life Insurance proceeds in the event of your death.

The designations you make on this form replace any prior beneficiary designations.

Designations apply to your Basic as well as any Optional Life Insurance you have under your Group Policy. If you would like different beneficiaries for your Basic and Optional coverages, please indicate that below.

See Page 2 of this form for sample beneficiary designations and more information.

### 1 Employee and employer information

Please print clearly

Your Name (first, middle initial, last)		Social Security Number	
Employer's Name	Group Policy Number	Billing Group Number	

### 2 Beneficiary Designation

For Primary Beneficiaries, indicate who should receive the Group Life Insurance proceeds in the event of your death.

For Secondary (also known as *Contingent*) Beneficiaries, indicate who should receive the Group Life Insurance proceeds in the event that ALL of your Primary Beneficiaries are not living at the time of your death.

Please make your beneficiary designation(s) below. If you need more space, attach another sheet to this form.

You may designate more than one Primary or Secondary Beneficiary. If you do, make sure to indicate the percentage share each should receive. The total within each class (Primary and Secondary) must equal 100%. If you do not specify percentages, surviving beneficiaries within the class will share proceeds equally.

Primary Beneficiary(ies)		Social Security Number	Relationship to Employee	Percent Share of Proceeds*
1.	Name: Address:			%
2.	Name: Address:			%

Secondary (Contingent) Beneficiary(ies)		Social Security Number	Relationship to Employee	Percent Share of Proceeds*
1.	Name: Address:			%
2.	Name: Address:			%

\* The total within each class (Primary and Secondary) must equal 100%.

### 3 Signature

**Employers:** Keep the signed original copy of this form with the employee's records.

**Important:** You must sign and date this form for your designation to become effective. Make a copy for your records and return the signed original to your employer.

Signature of Employee X	Date Signed
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Continued on next page

## Beneficiary Wording Alternatives

Proposed Beneficiary(ies)	Suggested Wording
1. Estate	Estate
2. One beneficiary	Martha Doe, wife
3. More than one beneficiary in equal shares	Jane Doe, Mary Doe and Richard Doe, children, or survivor(s) of them, in equal shares.
4. Two beneficiaries, in succession	Primary: Martha Doe, wife; Secondary: Richard Doe, son. <i>(Richard will only receive proceeds if Martha Doe is not living at the time of the employee's death.)</i>
5. One beneficiary followed by two beneficiaries in equal shares	Primary: Martha Doe, wife; Secondary: Jane Doe and Mary Doe, children in equal shares, or the survivor of them. <i>(Jane and Mary will only receive proceeds if Martha Doe is not living at the time of the employee's death.)</i>
6. More than one Beneficiary in equal shares per descendent order	Jane Doe, Mary Doe and Richard Doe, or the survivor(s) of them, in equal shares. However, if any of my children predecease me and leave issue who survive me, the issue of the deceased child will receive their parents' share in equal shares.
7. One or more minor children	John Smith, as custodian for Jane Doe, a minor, under the Uniform Transfers to Minors Act (UTMA) so that proceeds can be paid before the child reaches the age of majority.
8. To a church or non-profit organization	Name and address of the beneficiary organization.
9. Beneficiaries shown in percentages	John Smith, brother - 40%, or in the event of his death, to my estate; Alan Smith, brother 60%, or in the event of his death, to my estate.
10. Trust under Last Will and Testament	Proceeds to be paid to the Trustee under my Last Will and Testament.
11. Existing Trust	Jane Doe, Trustee of the Doe Family Trust, dated 1/1/2001.

**Please Note:** You cannot name your employer as a beneficiary for Group Life Insurance proceeds under the Group Policy.

Dependent Life Insurance benefits are payable to the employee, or the employee's estate if the employee does not survive the dependent.

**Sun Life Assurance Company of Canada is not a tax or legal advisor and the above information is provided as general information only. Before making beneficiary designations, you may want to consult with your tax or legal advisor.**

# 2008 UNIVERSITY OF LOUISVILLE Flexible Spending Account (FSA) Enrollment Form

PLEASE PRINT Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Street Address \_\_\_\_\_ Apartment Number \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_ Employee I.D. \_\_\_\_\_ Pay Basis, Biweekly or Monthly \_\_\_\_\_

I am waiving health coverage. Please include the university's contribution (\$1.95 per pay period for monthly employees and \$90 per pay period for biweekly employees, or an annual amount of \$2,340) in my FSA.

Enter the amount below that you wish to contribute for the remainder of the calendar year. Deductions will come from your paychecks in equal installments throughout the remainder of the year on a pre-tax basis. If not contributing, enter "0." The minimum amount you can put in an FSA is \$150.

	Employee Amount*	University Waiver Amount*	Total
<b>Annual Health Care Account</b> (Maximum amount allowed per year: \$5,000)	\$ _____	+ \$ _____	= \$ _____
<b>Dependent Care Account</b> (Maximum amount allowed per year: \$5,000; \$2,500 if married and filing separately)	\$ _____	+ \$ _____	= \$ _____

\*Amounts included here should reflect the remainder of this calendar year.

## FSA Authorization – Please Read and Sign

I understand that I have made an election for the FSA benefits shown for the period January 1 or my hire date (whichever is later) through December 31. Amounts committed to the flexible spending accounts may be changed only as permitted under rules described in the Summary Plan Description. I also understand that I will forfeit any money left in either account after payment of eligible expenses incurred during the calendar year. Use of any FSA funds to pay for benefits for an ineligible person(s) may constitute tax fraud and may lead to criminal prosecution.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

# HIGHLIGHTS OF

## Optional Life Insurance Benefits for Employees of University of Louisville - #40971



**Welcome to Sun Life Assurance Company of Canada**, a member of the Sun Life Financial group of companies.

We provide Optional Group Term Life Insurance to eligible employees of University of Louisville.

Your employer is offering you the opportunity to increase your Optional Life coverage – or enroll in it for the first time if you're not currently covered.

Enrollment in Optional Life is available for a limited time. Please see your employer for details.

This flyer highlights the benefits available through your employer. For more information, see the Sun Life Assurance Company of Canada Group Life booklet available from your employer.

### Benefits

- **For you:**  
Amounts of \$30,000, \$40,000, \$50,000, \$60,000, \$70,000, \$80,000, \$90,000, \$100,000, \$110,000, \$130,000, \$150,000, \$170,000 or \$200,000. All coverage amounts reduce to 65% at age 65. Benefits cease at retirement.
- **For your spouse:**  
Amount of \$10,000, \$15,000, \$20,000, or \$25,000. Spouse Optional Life coverage may not exceed 50% of the employee's coverage. Coverage ends when your spouse turns 70.
- **For your dependent child(ren):**  
You can purchase \$10,000 for each child ages 1 year up to age 25 years old, \$500 for ages 14 days to under 1 year. Dependent Child(ren) Optional Life coverage may not exceed 50% of the employee's coverage.  
  
You must elect Optional Life coverage for yourself in order to cover your spouse and/or children.

### Features of the Plan

- The plan includes many special features including Waiver of Premium and Accelerated Benefits. For more information, ask your employer for a copy of the flyer entitled "Optional Life Means Added Financial Security."

### About Evidence of Insurability

- Evidence of Insurability – also called "proof of good health" – is required if:
  - You decline coverage during your initial eligibility period and then want coverage at a later date.
- All late entrants and increases require Evidence of Insurability.
- Your employer will advise you if you need to provide Evidence of Insurability. If so, Sun Life Assurance Company of Canada may arrange for you to take a medical exam (at our expense) and/or complete a questionnaire. Coverage will not go into effect until Sun Life Assurance Company of Canada approves it.

### Optional Life Rates

- Use the rate chart on the Optional Life enrollment form to calculate how much your coverage will cost.

*Continued on next page*

## Highlights of Optional Life Insurance Benefits continued

### Enrolling in Optional Life is Easy

- Once you have selected the amount of coverage that's right for you, your spouse and your children, simply fill out the Optional Life enrollment form. Please submit the form to your employer along with any Evidence of Insurability forms that may be required.

### About Sun Life Assurance Company of Canada

- Sun Life Assurance Company of Canada is one of the largest, strongest and most highly rated financial services companies in the world. We provide Group Life and AD&D to more than 1.5 million employees in the United States.

### For Complete Plan Details

- This highlight flyer is intended to provide an overview of the benefits available from your employer, and is *not* a complete description of plan provisions. Receipt of this flyer does *not* certify eligibility for benefits under this plan.
- When you become eligible for benefits, your employer will provide you with the Sun Life Assurance Company of Canada Group Life booklet containing complete plan details.

# Sun Life Assurance Company of Canada

## Optional Life Enrollment Form



### 1 Employer, Employee and Dependent Information (Please print clearly)

Name of your employer <b>University of Louisville</b>	Policy number <b>40971</b>	Benefit group or class All Full Time Employees	Your annual basic earnings* \$		
Your full legal name (first, middle initial, last)	Social Security Number	Date of birth	Date of hire	Your occupation	
Your spouse's name (first, middle initial, last)**	Social Security Number	Date of birth	Date of marriage		
Name(s) of child(ren) to be covered (attach additional pages if needed)**			Date(s) of birth		

### 2 Benefit Elections (Make your benefit elections below based on the coverage options described here)

**For yourself:** Amounts of \$30,000, \$40,000, \$50,000, \$60,000, \$70,000, \$80,000, \$90,000, \$100,000, \$110,000, \$130,000, \$150,000, \$170,000 or \$200,000, not to exceed \$200,000. All coverage amounts reduce to 65% at age 65.

**For your spouse:** Amount of \$10,000, \$15,000, \$20,000 or \$25,000, not to exceed \$25,000. Spouse coverage cannot exceed 50% of the employee's Optional Life coverage. Coverage ends when your spouse turns 70 years old.

**For your eligible children:** You can purchase \$10,000, for child(ren) 1 year or older, or \$500 for child(ren) age 14 days, but under 1 year. For a description of children eligible for coverage, refer to your group insurance booklet or ask your employer.

	I elect coverage	I decline coverage	Coverage amount selected
Employee coverage:	<input type="checkbox"/>	<input type="checkbox"/>	\$
Spouse coverage**:	<input type="checkbox"/>	<input type="checkbox"/>	\$
Child(ren) coverage**:	<input type="checkbox"/>	<input type="checkbox"/>	\$

\* For most plans, "basic annual earnings" is defined as your salary. Basic annual earnings usually excludes bonuses, commissions or overtime. Please see your benefits booklet or check with your employer for the exact definition of earnings that applies to you.

\*\* Your spouse and children may only be covered if you are.

### 3 Acknowledgment and Signature (Important: You must read and sign for coverage)

I understand that:

- I am requesting Optional Life coverage under a Group Insurance policy offered by my employer. This coverage will end when my employment terminates.
- My employer will deduct all or part of the premiums from my pay.
- If I decline coverage for me or my family now and want it at a later date, I/we will have to provide evidence of insurability acceptable to Sun Life Assurance Company of Canada. I have read the "About Evidence of Insurability" notice on page 2.
- 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 thereto, commits a fraudulent insurance act, which is a crime and subjects a person to criminal and civil penalties.
- If I am not actively at work due to injury, illness, layoff or leave of absence on the date that any initial or increased Optional Life coverage is scheduled to start under the plan, such coverage will not start until the date I return to work.
- If my spouse or any of my dependent children are hospital-confined due to an injury or illness on the date that any initial or increased coverage is scheduled to start under the plan, such coverage will not start until the date they are no longer hospital-confined and are able to perform their normal activities.

Signature of employee X	Date signed
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Continued on Page 2

**About Evidence of Insurability**

Evidence of Insurability (EOI) is needed if:

- You apply for higher coverage than the limits described in the Coverage Options above.
- You want to increase your existing coverage now (whether your existing coverage is with Sun Life Assurance Company of Canada or a prior insurance carrier) or at a later date.
- You decline coverage and then want it at a later date.

If EOI is needed, your coverage will not go into effect until Sun Life Assurance Company of Canada approves it.

**4 Beneficiary Designation**

For Primary Beneficiaries, indicate who should receive the Optional Life Insurance proceeds in the event of your death.

For Secondary (also known as *Contingent*) Beneficiaries, indicate who should receive the Optional Life Insurance proceeds in the event that ALL of your Primary Beneficiaries are not living at the time of your death.

If you do not name a beneficiary, or if no beneficiaries are alive at the time of your death, proceeds will be payable to your estate.

**Use my Basic Life beneficiaries** – Check this box and leave this section blank if you want your Optional Life Insurance beneficiaries to be the same as your Basic Life beneficiaries.

If you did not check the box above, make your beneficiary designation(s) below. If you need more space, attach another sheet to this form.

You may designate more than one Primary or Secondary Beneficiary. If you do, make sure to indicate the percentage share each should receive. The total within each class (Primary and Secondary) must equal 100%.

Primary beneficiary(ies)		Social Security Number	Relationship to employee	Percent share of proceeds *
1.				
2.				

  

Secondary (Contingent) beneficiary(ies)		Social Security Number	Relationship to employee	Percent share of proceeds *
1.				
2.				

\* The total within each class (Primary and Secondary) must equal 100%.

**5 Calculating Your Cost**

(Find your monthly cost by adding all of the coverages you have selected)

**Employee and spouse coverage:**

1. Find your/your spouse's age in the chart below and the corresponding cost.
2. Multiply the cost per \$1,000 by your/your spouse's amount of coverage (divided by 1,000). Your cost will increase when you or your spouse moves into a new age band.

**Child(ren) coverage:**

1. Find the cost per \$1,000 for child(ren) coverage in the chart below.
2. Multiply the cost per \$1,000 by your child(ren)'s amount of coverage (divided by 1,000).

EMPLOYEE		SPOUSE		CHILD(REN)	
Age	Monthly cost per \$1,000 of coverage**	Age	Monthly cost per \$1,000 of coverage	Monthly cost per \$1,000 of coverage	
Under 25	\$ 0.054	Under 25	\$ 0.054		
25 – 29	\$ 0.065	25 – 29	\$ 0.065		
30 – 34	\$ 0.087	30 – 34	\$ 0.087		
35 – 39	\$ 0.098	35 – 39	\$ 0.098		
40 – 44	\$ 0.109	40 – 44	\$ 0.109	All eligible children	\$ 0.123
45 – 49	\$ 0.163	45 – 49	\$ 0.163		
50 – 54	\$ 0.250	50 – 54	\$ 0.250		
55 – 59	\$ 0.467	55 – 59	\$ 0.467		
60 – 64	\$ 0.717	60 – 64	\$ 0.717		
65 – 69	\$ 1.379	65 – 69	\$ 1.379		
70 +	\$ 2.237	70 +	\$ 2.237		

**Employee:** Make a copy of this form for your records before submitting it to your employer.

**Employers:** This original enrollment form should remain at the employer's site. Family status, coverage, or beneficiary changes should be recorded on another Optional Life Enrollment Form.

## 2008 ANTHEM VISION AND DENTAL APPLICATION

Hire Date/ Effective Date		Last Name	First Name, Middle Initial	Social Security Number
Street Address		City	State	Zip Code
Date of Birth	Employee ID Number	Home Phone Number (    )		Gender (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female

**I wish to apply for:**

**Check one:**     Anthem Blue View *VISION ONLY*  
                    Anthem *DENTAL Blue ONLY*  
                    BOTH Anthem *DENTAL and VISION*

**:Dental**

Single                     Employee & Spouse                     Employee & Child(ren)                     Family

**Vision**

Single                     Employee & Spouse                     Employee & Child(ren)                     Family

**Spouse and/or Children to be covered by Dental**

Last Name	First Name	Date of Birth	Gender	Relationship	Disabled?

**Spouse and/or Children to be covered by Vision**

Last Name	First Name	Date of Birth	Gender	Relationship	Disabled?

**True and complete acknowledgement**

I understand, agree and represent:

Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. I hereby enroll for benefits for which I am presently eligible or for which I may become eligible under my employer's group contract(s). If any deductions are required for this coverage, I authorize such deductions from my earning. I reserve the right to revoke this deduction authorization at any time upon written notice unless I have chosen to use pretax deductions. This document, together with any supplements, will form part of any contract and be the basis for any certificate of coverage/certificate of insurance issued.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

**University of Louisville**  
**Affidavit of Qualifying Adult For Benefit Coverage**

Confidential

**Employee Information**

Employee Name (Last, First, Middle):				
Date of Birth:	Phone	Employee ID:		
Address:	City:	State:	Zip Code:	

**Qualifying Adult Information**

Qualifying Adult Name (Last, First, Middle):		
Date of Birth:	Gender (Circle One): M          F	Social Security Number:
Relationship to Employee:		<b>Note: An employee may cover his/her legal spouse OR one qualifying adult on his/her U of L medical plan, but not both.</b>

**Declaration**

We, the undersigned, certify that the Qualifying Adult named above:

- Is age 18 or older and mentally competent to consent, and
- Is either not related by blood to the employee, or if a blood relative (or relative by adoption or marriage) is of the same or younger generation of the employee (as used in KRS 391.010), and
- Is not legally married to anyone, and
- Is not currently eligible for any part of Medicare, and that
- We share a residence and have done so for at least twelve consecutive months prior to this declaration, and that
- We are jointly responsible for each other's financial obligations which could be demonstrated upon request by providing proof of existence of at least one of the following (please check):
  - A joint mortgage or lease or other evidence of common residence such as joint utility bills
  - Durable property or health care power of attorney
  - Joint ownership of a motor vehicle
  - Joint checking account/credit account
  - Designation of each other as the primary beneficiary in a will, life insurance policy, or retirement plan

I agree to notify the university within 30 days if any eligibility requirements listed above are no longer satisfied which would make the qualifying adult no longer eligible for coverage.

We certify that the information included here is true and correct and understand that a false declaration of a qualifying adult or failure to file a timely termination notice with the university if this qualification ends may result in disciplinary action up to and including termination of employment at the University of Louisville. We agree that in the event of a false declaration, or the failure to file a timely termination notice if this eligibility ends, the university may recover damages from either or both of us for all costs and expenses incurred by the university as a result of that false declaration, including, without being limited to, attorneys' fees incurred by the university to recover such damages. See university policy PER 5.01.

Employee Signature	Date	Qualifying Adult Signature	Date

## **Qualifying Adult**

### **Eligibility**

A Qualifying Adult:

- Must be over 18 years of age, and
- Must not be eligible for Medicare, and
- If a blood relative (or relative by adoption or marriage) must be of the same or younger generation of the employee (as used in KRS 391.010), and
- Must be residing in the employee's household and have done so for a period of at least 12 months, and
- Must be financially interdependent (for example, have joint checking account or joint mortgage) for 12 months or longer, and
- Must be unmarried.

### **Things you need to know**

#### **Employee pays for cost of qualifying adult**

An employee has the choice of covering his/her legal spouse OR one qualifying adult on his/her UofL medical plan, but not both. The employee bears the full cost of covering a Qualified Adult and the Qualifying Adult's children, if any.