2026 Retiree Medical Enrollment Form

Submit this form postmarked no later than October 31, 2025 by e-mail at benefits@louisville.edu or mail to University of Louisville Human Resources, 215 Central Ave, Suite 205, Louisville, KY 40208.

Last Name	First Name, Middle Initial	Last 4 digits SSN	Date of Birth	Gender
Street Address, City, State	**Zip Code**	**Phone Number**	**Employee ID Number**	

Medical Plan (Choose the same plan option you had upon retiring, and you or your spouse/QA must be under the age of 65)

Select your plan option	☐ PPO	☐ ULH	☐ CDHP	☐ None
Select who you want to cover	☐ Single	☐ Retiree + Spouse/QA	☐ Retiree + Child(ren)	☐ Family

Spouse/QA and/or dependents to be covered

Name	Social Security #	Date of Birth	Gender	Relationship	Disabled (Y/N)	Medical
						☐
						☐
						☐
						☐

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). I understand I am responsible for paying for my premiums through the university's billing service, Optum, by the date it is due and failure to pay will result in loss of coverage. 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.

Signature _____ **Date** _____