

Employee Information		
Employee Name (First, Last)	Employee ID #	DOB
Street Address	City, State, Zip	Phone
Retirement Information		
Employment Date	Last Day Worked	Retirement Age
Benefit Elections (check boxes for coverage)		
Medical Insurance for retiree and/or spouse under age 65		
Continue current coverage		I do not wish to continue
Employee Only	Spouse Only    Empl+Spouse	Empl+Child(ren)    Empl+Family
AARP Supplemental Plan for retiree and/or spouse at or over age 65		
I wish to participate		I do not wish to participate
Employee Only	Spouse Only    Empl+Spouse	
Retiree Term Life Insurance Options		
I wish to participate at the level selected below		I do not wish to participate
\$5,000	\$10,000    \$15,000 <sup>1</sup> \$20,000 <sup>1</sup>	\$25,000 <sup>1</sup>
Spouse Term Life Insurance (Retiree must be enrolled in Retiree Term Life Insurance) <sup>2</sup>		
I wish to participate		I do not wish to participate
Spouse Name	Spouse DOB	Spouse SSN
Dependent Child Life Insurance (coverage of \$5,000 must be enrolled in Retiree Term Life Ins) <sup>2</sup>		
I wish to participate		I do not wish to participate
Child's Name	Child's DOB	Child's SSN
Child's Name	Child's DOB	Child's SSN

<sup>1</sup>Amounts over \$10,000 for retiree term life insurance will require a statement of health

<sup>2</sup>Spouse and Dependent Child coverage may require a statement of health (*Child must be 1-18 yrs or 19-26 yrs and a full-time student*)

I wish to continue the coverages selected above for which I am eligible and understand that I will be billed directly by the University of Louisville's direct billing partner for my elected coverage(s). I understand that payment must be made within 30 days of the payment due date for coverage to continue.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date