University of Louisville
Retiree Continuation of Benefits Form

Employee Information

Name	Employee ID	DOB
Street Address	**City, State, Zip**	**Phone**

Retirement Information

Employment Date	Last Day Worked	Retirement Age

Benefit Elections for Health, Dental & Vision (check your choices for coverage)

Health Insurance (for retiree or spouse under the age of 65)

☐ Continue Current Coverage ☐ I do not wish to participate

◯ Employee Only ◯ Employee+Spouse ◯ Employee+Child(ren) ☐ Employee+Family

Dental Insurance

☐ Continue Current Coverage ☐ I do not wish to participate

◯ Employee Only ◯ Employee+Spouse ◯ Employee+Child(ren) ☐ Employee+Family

Vision Insurance

☐ Continue Current Coverage ☐ I do not wish to participate

◯ Employee Only ◯ Employee+Spouse ◯ Employee+Child(ren) ☐ Employee+Family

AARP Supplemental Plan (for retirees or spouse at or over the age of 65)

☐ Yes, I wish to participate ☐ I do not wish to participate

☐ Employee Only ◯ Employee+Spouse

Term Life Insurance Options

Retiree Term Life Insurance

☐ Yes, I wish to participate at the level selected below ☐ I do not wish to participate

◯ $5,000 ◯ $10,000 ◯ $15,000[1] ◯ $20,000[1] ◯ $25,000[1]

Spouse Term Life Insurance (Coverage of $5,000. Must be enrolled in Retiree Term Life Insurance)[2]

☐ Yes, I wish to participate ☐ I do not wish to participate

Spouse's Name	DOB:	SSN:

Dependent Child Life Insurance (Coverage of $5,000. Must be enrolled in Retiree Term Life Insurance)[2]

☐ Yes, I wish to participate ☐ No, I do not wish to participate

Child's Name	DOB:	SSN:
Child's Name	**DOB:**	**SSN:**

[1] Amounts over $15,000 for retiree term life insurance will require a statement of health.
[2] Spouse and Dependent Child coverage may require a statement of health.

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 coverage for my elected coverage(s). I understand that payment must be made within 30 days for coverage to continue.

SIGNATURE _____ DATE _____