PROVIDER NOMINATION FORM

Don't see your dentist or optometrist on current provider directory? We know how important it is to have access to a provider your feel comfortable with. Please help us by recommending your dentist or vision for our networks. We will contact your provider and make every effort to recruit him or her into our growing network of participating providers.

Vision

Provider Name:

Practice Name:

Address:

City:

State: **Zip:**

Phone:

Dental

Provider Name:

Practice Name:

Address:

City:

State: **Zip:**

Phone:

Employer Name: **Commonwealth of Kentucky Employees #20108**

Your Name (optional):

Date:

By placing your name above, we may tell your provider that you have asked us to contact him or her to participate. It has been shown that providers appreciate recommendations by their clients. Your nominated provider will be contacted by one of our network representatives with 5 to 7 business days.

Please fax to Krol Insurance Agency at 502-875-3615.