



Eligibility Change Form

Group Name: Commonwealth of Kentucky # 20108 **KY Company Name** _____

Enrollee Name: _____ **SS#** _____ - _____ - _____
OR Payroll ID _____

1) Enrollee Changes:
 Name (enrollee): From: _____
 To: _____
 Address To: _____
 City: _____ State _____ Zip _____
 Telephone To: () _____

Dependents Changes:
Add:
 Name _____ Birth Date ___/___/___ Male ___ Female ___
 Name _____ Birth Date ___/___/___ Male ___ Female ___
 Name _____ Birth Date ___/___/___ Male ___ Female ___
Delete:
 Name _____ Birth Date ___/___/___ Male ___ Female ___
 Name _____ Birth Date ___/___/___ Male ___ Female ___
 Name _____ Birth Date ___/___/___ Male ___ Female ___

2) Terminate Coverage (Reason) _____
 _____ Date of Termination ___/___/___

3) Reinstate Coverage (Reason) _____
 _____ Effective Date of Reinstatement ___/___/___

4.) Plan Change (available after one year):
DENTAL
 From:
 Employee Bronze
 Employee Gold
 To:
 Employee Bronze
 Employee Gold
 Retiree (see Agency Administrator)

Plan Change (available after one year):
VISION
 From:
 Employee
 To:
 Retiree (see Agency Administrator)

New Premium Deduction:
 \$ _____
 (Note: Check payroll deduction for correct deductions amount.)

5) Other (Explain) _____

Effective Date of Change: ___/___/___ (DATE MUST BE THE 1ST OF THE TERMINATION MONTH)

Signature _____
 Authorized party (enrollee, administrator, etc.)

Fax Changes to: Krol Insurance Agency 502-875-3615