

CITIZENS SECURITY LIFE INSURANCE COMPANY

12910 Shelbyville Road Ste. 300

Louisville, KY 40243

Commonwealth of Kentucky

Employee Dental Application 2023

Wage Types# 5731

PLEASE COMPLETE THE FOLLOWING INFORMATION:

Social Security #:	Last Name:	First Name:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Address:			
City:	State:	Zip Code:	Phone #: () -
E-Mail Address:	Date of Birth: / /	Age:	Business Phone #: () - Ext #:

DEPENDENT INFORMATION

NAME:	FIRST	M.I.	LAST	GENDER	DATE OF BIRTH
SPOUSE:				<input type="checkbox"/> M <input type="checkbox"/> F	
CHILD:				<input type="checkbox"/> M <input type="checkbox"/> F	
CHILD:				<input type="checkbox"/> M <input type="checkbox"/> F	
CHILD:				<input type="checkbox"/> M <input type="checkbox"/> F	
CHILD:				<input type="checkbox"/> M <input type="checkbox"/> F	

PLAN INFORMATION

Number of Dependents:	KY Group #:	Fax Number:	Payroll Clerk:	1st Payroll Deduction:
Company Name: Commonwealth of KY		Group Number:	Agent Number:	Policy Effective Date:
Dept. Name:		20108 Acct: 1002	A73157864	/01/2023

PLEASE CHOOSE YOUR DENTAL COVERAGE FOR THE 12 MONTH BENEFIT PERIOD

PRIOR COVERAGE: <input type="checkbox"/> Yes <input type="checkbox"/> No	EPO BRONZE	FREEDOM GOLD
If yes, company name: _____	<input type="checkbox"/> Single \$ 25.79	<input type="checkbox"/> Single \$ 34.25
Policy effective date: _____	<input type="checkbox"/> Employee + 1 \$ 48.56	<input type="checkbox"/> Employee + 1 \$ 64.52
Coverage level <input type="checkbox"/> EE <input type="checkbox"/> EE+1 <input type="checkbox"/> Family	<input type="checkbox"/> Employee + Family \$ 76.42	<input type="checkbox"/> Employee + Family \$101.52

PLEASE CHECK PAYROLL DEDUCTION FOR CORRECT DEDUCTIONS.

SEND TO: DENNIS KROL INSURANCE PO BOX 1818 FRANKFORT, KY 40602-1818 www.denniskrolinsurance.com	CALL: 800.467.5765 OR 502.875.3477 FAX: 502.875.3615 EMAIL: krolinsurance@bellsouth.net
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AUTHORIZATION

I hereby request coverage under the group policy(ies) issued by CITIZENS SECURITY LIFE INSURANCE COMPANY of Louisville, KY and authorize my employer to deduct from my earnings any required contribution for the insurance to which I am or may become entitled. I am employed by the employer listed above and regularly work and, at present I am working at least 30 hours per week for this employer at a regular place of business or other location to which I am required to travel to perform my regular duties for this employer. I hereby represent that all answers above are true and complete to the best of my knowledge and belief.

Any person who knowingly and with 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 act, which is a crime.

Applicant's Signature:	Date:
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