

<b>PLEASE COMPLETE:</b>											
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:		Alternate Phone #: (    )    -				
<b>DEPENDENT INFORMATION – COMPLETE ALL INFORMATION FOR EACH DEPENDENT(S) TO BE COVERED. CHILD(REN) AGES 19-25 MUST ATTEND SCHOOL FULL-TIME)</b>											
<b>NAME:</b>				<b>DATE OF BIRTH:</b>		<b>SEX (M/F)</b>	<b>DENTAL (Y/N)</b>	<b>VISION (Y/N)</b>			
<b>FIRST                      M.I.                      LAST</b>											
<b>SPOUSE:</b>				/ /							
<b>CHILD:</b>				/ /							
<b>CHILD:</b>				/ /							
<b>PLAN INFORMATION</b>											
Total Number of Dependents Covered: _____			Policy Eff. Date: ____/01/2024			Group Number 20108		Agent Number: A73157864			
<b>PLEASE CHECK YOUR CHOICE OF DENTAL AND/OR VISION COVERAGE AND PAYMENT OPTION</b>											
<b>DENTAL</b>			<b>SELECT PAYMENT OPTION</b>			<b>VISION</b>			<b>SELECT PAYMENT OPTION</b>		
			Monthly Pay			Monthly Pay			Annual Pay		
<input type="checkbox"/> Single			<input type="checkbox"/> \$38.12			<input type="checkbox"/> \$8.82			<input type="checkbox"/> \$100.61		
<input type="checkbox"/> EE + 1			<input type="checkbox"/> \$71.73			<input type="checkbox"/> \$18.84			<input type="checkbox"/> \$214.89		
<input type="checkbox"/> EE + Family			<input type="checkbox"/> \$113.02			<input type="checkbox"/> \$24.43			<input type="checkbox"/> \$278.57		
<b>PRIOR COVERAGE</b>			<input type="checkbox"/> YES <input type="checkbox"/> NO			<b>Dental and Vision Benefit Coverage is for a 12 Month Period.</b>					
If yes, company name _____											
<b>PAYMENT AND SUBMISSION INSTRUCTIONS</b>											
<b>FOR BANK DRAFT:</b> Complete and sign the authorization form below. Coverage will be effective the 1 <sup>st</sup> of the month following the initial deduction.					<b>FOR ANNUAL PAY:</b> send your payment in the amount indicated along with your application. Make your check payable to Citizens Security Life Insurance Company.						
<b>SEND COMPLETE APPLICATION TO: DENNIS KROL INSURANCE • PO BOX 1818 • FRANKFORT, KY 40602-1818 FAX: 502-875-3615 DIRECT LINE: 502-875-3477 TOLL FREE: 800.467.5765 EMAIL: <a href="mailto:krolinsurance@bellsouth.net">krolinsurance@bellsouth.net</a></b>											
<b>AUTHORIZATION</b>											
<b>ELECTRONIC FUNDS AUTHORIZATION FORM ( Attach voided check or copy)</b>											
Name of Financial Institution (Bank) _____											
Street Address _____			City _____			State _____		Zip Code _____			
Routing Number _____			Account Number _____			<input type="checkbox"/> <b>Checking Account</b>					
<input type="checkbox"/> <b>Savings Account</b>											
I hereby authorize and direct you to honor and charge to my account checks drawn on my account by and payable to Citizens Security Life Insurance Company. The signatures on such checks may be typed or printed. You shall have no liability for the return unpaid of any such check if the balance in my account is insufficient to pay the same upon presentation. This authorization shall continue in force until revoked by me in writing, a copy of which revocation shall be sent to Citizens Security Life Insurance Company.											
* ON THE _____ DAY OF THE MONTH (Must be the 1 <sup>st</sup> thru the 28 <sup>th</sup> ) <b>Please check bank records for correct deductions.</b>											
<b>Signature of Premium Payor EXACTLY as it appears on bank records:</b> _____											
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.											
<b>Applicant's Signature:</b>								<b>Date:</b>			