CS Benefits
Service with a Human Touch.

# 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 ____/_1_/____

**3) Reinstate Coverage** (Reason) _____

_____ Effective Date of Reinstatement ___/_1_/___

**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**: ___/_1_/___**(DATE MUST BE THE 1ST OF THE TERMINATION MONTH)**

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

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

**CWCH2013**