CITIZENS SECURITY LIFE INSURANCE COMPANY
12910 Shelbyville Rd. Ste. 300 Louisville KY 40243

Commonwealth of Kentucky
Retiree Dental / Vision Application 2024

PLEASE COMPLETE:			
Social Security #:	Last Name: First Name:		Sex: ☐ Male ☐ Female
Address:			
City:	State:	Zip Code:	Phone #: ( ) -
E-Mail Address:	Date of Birth: / /	Age:	Alternate Phone #: ( ) -

DEPENDENT INFORMATION – COMPLETE ALL INFORMATION FOR EACH DEPENDENT(S) TO BE COVERED. CHILD(REN) AGES 19-25 MUST ATTEND SCHOOL FULL-TIME)

NAME: FIRST M.I. LAST	Date of Birth	Sex (M/F)	Dental (Y/N)	Vision (Y/N)
SPOUSE:	/ /			
CHILD:	/ /			
CHILD:	/ /			

PLAN INFORMATION

Total Number of Dependents Covered: _____	Policy Eff. Date: _____/01/2024	Group Number 20108	Agent Number: A73157864

PLEASE CHECK YOUR CHOICE OF DENTAL AND/OR VISION COVERAGE AND PAYMENT OPTION

DENTAL	**SELECT PAYMENT OPTION**	
	Monthly Pay	Annual Pay
☐ Single	☐ $38.12	☐ $434.71
☐ EE + 1	☐ $71.73	☐ $818.02
☐ EE + Family	☐ $113.02	☐ $1,288.81

VISION	**SELECT PAYMENT OPTION**	
	Monthly Pay	Annual Pay
☐ Single	☐ $8.82	☐ $100.61
☐ EE + 1	☐ $18.84	☐ $214.89
☐ EE + Family	☐ $24.43	☐ $278.57

PRIOR COVERAGE ☐ YES ☐ NO
If yes, company name _____

Dental and Vision Benefit Coverage is for a 12 Month Period.

PAYMENT AND SUBMISSION INSTRUCTIONS

FOR BANK DRAFT: Complete and sign the authorization form below. Coverage will be effective the 1st of the month following the initial deduction.

FOR ANNUAL PAY: Send your payment in the amount indicated along with your application. Make your check payable to Citizens Security Life Insurance Company.

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: krolinsurance@bellsouth.net

AUTHORIZATION

ELECTRONIC FUNDS AUTHORIZATION FORM *(Attach voided check or copy)*

Name of Financial Institution (Bank) _____

Street Address _____ **City** _____ **State**_____ **Zip Code** _____

Routing Number_____ **Account Number**_____

❑ **Checking Account**
❑ **Savings Account**

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 1st thru the 28th)* ***Please check bank records for correct deductions.***

Signature of Premium Payor EXACTLY as it appears on bank records: _____

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:**