

**CITIZENS SECURITY LIFE INSURANCE COMPANY**

4350 Brownsboro Road Ste. 200

Louisville, KY 40207

Commonwealth of Kentucky

Employee Dental Application 2026

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
<b>SPOUSE:</b>				<input type="checkbox"/> M <input type="checkbox"/> F	
<b>CHILD:</b>				<input type="checkbox"/> M <input type="checkbox"/> F	
<b>CHILD:</b>				<input type="checkbox"/> M <input type="checkbox"/> F	
<b>CHILD:</b>				<input type="checkbox"/> M <input type="checkbox"/> F	
<b>CHILD:</b>				<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: 20108 Acct: 1002	Agent Number: A73157864	Policy Effective Date: /01/2026
Dept. Name:				

**PLEASE CHOOSE YOUR DENTAL COVERAGE FOR THE 12 MONTH BENEFIT PERIOD**

<b>PRIOR COVERAGE:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>EPO BRONZE</b>	<b>FREEDOM GOLD</b>
If yes, company name: _____	<input type="checkbox"/> Single \$ 28.63	<input type="checkbox"/> Single \$ 38.02
Policy effective date: _____	<input type="checkbox"/> Employee + 1 \$ 53.90	<input type="checkbox"/> Employee + 1 \$ 71.62
Coverage level <input type="checkbox"/> EE <input type="checkbox"/> EE+1 <input type="checkbox"/> Family	<input type="checkbox"/> Employee + Family \$ 84.83	<input type="checkbox"/> Employee + Family \$112.69

**PLEASE CHECK PAYROLL DEDUCTION FOR CORRECT DEDUCTIONS.**

<b>SEND TO:</b> DENNIS KROL INSURANCE PO BOX 1818 FRANKFORT, KY 40602-1818 <a href="http://www.denniskrolinsurance.com">www.denniskrolinsurance.com</a>	CALL: 800.467.5765 OR 502.875.3477 FAX: 502.875.3615 EMAIL: <a href="mailto:krolinsurance@bellsouth.net">krolinsurance@bellsouth.net</a>
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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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