

Commonwealth of Kentucky

2012 Retiree Dental Application

PLEASE COMPLETE:

Social Security #:	Last Name:	First Name:	M.I.:
Address:			
City:	State:	Zip Code:	Phone #: () -
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: / /	Age:	Alternate Phone #: () -

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	

PLAN INFORMATION

Total Number of Dependents Covered:	E-Mail Address:
Group Number: 20108	Agent Number: A73157864
Policy Effective Date:	

PLEASE CHECK YOUR CHOICE OF DENTAL COVERAGE UNDER THE PREFERRED PAYMENT METHOD

FREEDOM GOLD RETIREE—Monthly Bank Draft	FREEDOM GOLD RETIREE—Annual Pay
<input type="checkbox"/> Single \$ 28.57	<input type="checkbox"/> Single \$ 325.87
<input type="checkbox"/> Employee + 1 \$ 53.77	<input type="checkbox"/> Employee + 1 \$ 613.21
<input type="checkbox"/> Employee + Family \$ 84.72	<input type="checkbox"/> Employee + Family \$ 966.12

PAYMENT AND SUBMISSION INSTRUCTIONS

FOR BANK DRAFT: Complete and sign the authorization form below. Coverage will be effective the 1 st 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.
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SEND COMPLETE APPLICATION TO:
DENNIS KROL INSURANCE • PO BOX 1818 • FRANKFORT, KY 40602-1818 • 800.467.5765

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)

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:
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