

Commonwealth of Kentucky

2012 Retiree Vision 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
<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	

**PLAN INFORMATION**

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

**PLEASE CHECK YOUR CHOICE OF VISION COVERAGE UNDER THE PREFERRED PAYMENT METHOD**

Monthly Bank Draft	Annual Pay
<input type="checkbox"/> Single \$ 8.82	<input type="checkbox"/> Single \$ 100.61
<input type="checkbox"/> Employee + 1 \$ 18.84	<input type="checkbox"/> Employee + 1 \$ 214.89
<input type="checkbox"/> Employee + Family \$ 24.43	<input type="checkbox"/> Employee + Family \$ 278.57

**PAYMENT AND SUBMISSION INSTRUCTIONS**

<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.
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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 1<sup>st</sup> thru the 28<sup>th</sup>)

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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