Utility Code # 1015 CompBenefits Dental Enrollment Form

Please complete the following information:					
Social Security No.	Last Name		First	MI	Date of Birth
Home Address			Home Phone		Sex M ☐ F☐
City	State	ZIP Code	Business Phone		Dental Facility # (C250z)

List All Your Eligible Dependents That Are To Be Covered			
First/ MI/ Last	Facility # (C250Z)	Sex	Birth Date
Spouse:		M ☐ F☐	
Child:		M ☐ F☐	
Child:		M ☐ F☐	
Child:		M ☐ F☐	
Child:		M ☐ F☐	

# Dependents Covered		E-mail Address	
Department Name:	Group Number	Agent Code 0102041KY	Policy Effective Date

Please check your choice

C250Z	**AVK3**	
❑ Employee: $13.00 ❑ Employee + One: $26.00 ❑ Employee + Family: $39.00 *Select Facility #*	❑ Employee: $17.36 ❑ Employee + One: $32.36 ❑ Employee + Family: $45.44	***Send to***: Dennis Krol Insurance P.O. Box 1818 Frankfort,KY 40602-1818 ***Or fax to:*** 502-875-3615 ***Or call:*** 800-467-5765, 502-875-3477

I wish to enroll in the dental plan indicated above as offered through my employer. I hereby authorize my employer to deduct all applicable contribution amounts from my salary or other compensation for the plan year, and for future renewal period(s). I understand that such contribution rate is subject to change on the anniversary date of the plan. I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

Signature: X _____ Date: _____

Return to Krol Insurance, P.O. Box 1818, Frankfort, KY 40602