Anthem Customer Service
1.844.402.5347

KENTUCKY PERSONNEL CABINET | Department of Employee Insurance

2022 DENTAL INSURANCE ENROLLMENT/CHANGE FORM

Section 1: To Be Completed by IC/HRG

KHRIS Personnel Number	Date of Hire	Effective Date	Organizational Unit #	Cost Center #	Company #

Section 2: To Be Completed by Employee

Employee's SSN	Name (Last, First, Middle)	Date of Birth

Mailing Address	City, State ZIP	Home County

Primary Phone #	Secondary Phone #	Work Email Address	Home Email Address

Section 3: Enrollment Changes

Reason	If Qualifying Event, check item below – *All of these require supporting documentation*	
☐ New Hire	☐ Divorce/Legal Separation/Annulment	☐ Birth/Adoption of Child/Placement for Adoption
☐ Open Enrollment	☐ Death of a Child or Spouse	☐ Guardianship/Court Order
☐ New Group	☐ Marriage	☐ Military Leave Without Pay
☐ Qualifying Event (QE), Date: ___________	☐ Loss of Coverage	☐ Other Open Enrollment
☐ Term current coverage due to QE	☐ Spouse/Dependent Gained Employment	

Termination or Transfer – Note: If transfer - This is to be completed by the **NEW** company & no changes to current coverage allowed.

Prior Company #:	Last Day worked:	Coverage End date:

Section 4: Coverage Level

☐ Single(self only) ☐ Parent Plus (self and child(ren)) ☐ Couple (self and spouse) ☐ Family (self, spouse and child(ren))

Section 5: Plan Options and Monthly Rates

	Single	Parent Plus	Couple	Family
☐ Dental Bronze	$13.28	$31.50	$24.22	$46.48
☐ Dental Silver	$20.18	$43.32	$38.32	$64.40
☐ Dental Gold	$26.78	$66.04	$51.78	$96.32

Section 6: Dependent Information

Spouse SSN:	Spouse Name (Last, First, MI)	Date of Birth (mm/dd/yyyy):	☐ Male ☐ Female
Child #1 SSN:	Child #1 Name (Last, First, MI)	Date of Birth (mm/dd/yyyy):	☐ Male ☐ Female
Child #2 SSN:	Child #2 Name (Last, First, MI)	Date of Birth (mm/dd/yyyy):	☐ Male ☐ Female
Child #3 SSN:	Child #3 Name (Last, First, MI)	Date of Birth (mm/dd/yyyy):	☐ Male ☐ Female
Child #4 SSN:	Child #4 Name (Last, First, MI)	Date of Birth (mm/dd/yyyy):	☐ Male ☐ Female

Section 5: Signatures – Please submit this application to your Company Insurance Coordinator

- I understand that I am applying for optional dental benefits offered as an employee benefit and fully insured by Anthem. By typing my name in the space provided below, I am signing this application electronically and am agreeing to conduct this transaction by electronic means.
- By signing this application, I certify that the information provided in this application is true and correct to the best of my knowledge. I also certify that I have read, understand, and agree to the Terms and Conditions of Participation and the Legal Notices. These documents can be found in your Benefits Selection Guide or online at kehp.ky.gov.

____ _______________________
Employee Signature Date

____ _______________________
IC/HRG Signature and Printed Name Date Telephone