CITIZENS SECURITY LIFE INSURANCE COMPANY
P.O. BOX 436149 • Louisville, KY 40253-6149
www.thecsbenefits.com
800.843.7752

GROUP EMPLOYEE ENROLLMENT / CHANGE FORM

ENROLLMENT / CHANGE TYPE			CITIZENS SECURITY USE ONLY	
☐ **New Applicant**			Dental Plan:	Dental Prem:
☐ **Change in Coverage:**			Vision Plan:	Vision Prem:
☐ Change Address ☐ Change Name ☐ Add Dependent	☐ Terminate effective: / / ☐ Reinstate effective: / / ☐ COBRA effective: / /		Waiting Period:	PID:
			Takeover: ☐ Y ☐ N Date: / /	
COVERAGE REQUESTED			**EMPLOYER USE ONLY**	
☐ **Dental**	**Dual Choice ONLY:**	☐ **High Option** ☐ **Low Option**	Group #:	Acct#:
☐ **Vision**	**Dual Choice ONLY:**	☐ **High Option** ☐ **Low Option**	Effective Date:	

APPLICANT INFORMATION

Last Name:	First Name:	M.I.:	Social Security #: XXX – XX -	
Address:			Phone #: ( ) -	
City:	State:	Zip Code:	Gender: ☐M ☐F	Married? ☐Y ☐N
Date of Birth: / /	Age:	Coverage Type: EE Only ☐ EE + Spouse ☐ EE + Child(ren) ☐ Family ☐		

EMPLOYER INFORMATION

Employer:	Location:	Phone #: ( ) -
Occupation / Title:	Hours Worked Per Week:	Full Time Employment Date: / /

DEPENDENT INFORMATION

All information must be completed for each dependent(s) to be covered. Select what coverage you want for each dependent(s) by placing a "Y" for Yes or "N" for No under the Dental and Vision columns. *(Child(ren) Ages 0-25)*

Name	Relation	Date of Birth	Sex (M/F)	Dental (Y/N)	Vision (Y/N)	If covered under another Dental Policy list the carrier

AUTHORIZATION

I hereby request coverage under the group policy(ies) issued by CITIZENS SECURITY LIFE INSURANCE COMPANY 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 or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Applicant's Signature:	Date: