Anthem Customer Service

1.844.402.5347

**2023 DENTAL INSURANCE ENROLLMENT/CHANGE FORM**

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| **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** |
| [ ]  New Hire[ ]  Open Enrollment[ ]  New Group[ ]  Qualifying Event (QE), Date: \_\_\_\_\_\_\_\_\_\_\_[ ]  Term current coverage due to QE  | [ ]  Divorce/Legal Separation/Annulment[ ]  Death of a Child or Spouse[ ]  Marriage[ ]  Loss of Coverage[ ]  Spouse/Dependent Gained Employment | [ ]  Birth/Adoption of Child/Placement for Adoption[ ]  Guardianship/Court Order[ ]  Military Leave Without Pay[ ]  Other Open Enrollment |
| **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 | $14.08 | $33.40 | $25.68 | $49.28 |
| [ ]  Dental Silver | $21.40 | $45.92 | $40.62 | $68.26 |
| [ ]  Dental Gold | $28.40 | $70.00 | $54.90 | $102.10 |
| **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](https://personnel.ky.gov/Pages/healthinsurance.aspx).
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| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Employee Signature Date

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