



2019 VISION 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
Street Address			City, State ZIP		Home County
Primary Phone #	Secondary Phone #	Work Email Address		Home Email Address	
Section 3: Enrollment Changes					
Reason					
<input type="checkbox"/> Open Enrollment					
Section 4: Coverage Level					
<input type="checkbox"/> Single(self only)		<input type="checkbox"/> Parent Plus (self and child(ren))		<input type="checkbox"/> Couple (self and spouse)	
<input type="checkbox"/> Family (self, spouse and child(ren))					
Section 5: Plan Options and Monthly Rates					
	Single	Parent Plus	Couple	Family	
<input type="checkbox"/> Vision Bronze	\$5.52	\$11.22	\$10.94	\$16.64	
<input type="checkbox"/> Vision Silver	\$6.46	\$13.12	\$12.80	\$19.48	
<input type="checkbox"/> Vision Gold	\$13.12	\$26.80	\$26.14	\$39.82	
Section 6: Dependent Information					
Spouse SSN:	Spouse Name (Last, First, MI)	Date of Birth (mm/dd/yyyy):	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Child #1 SSN:	Child #1 Name (Last, First, MI)	Date of Birth (mm/dd/yyyy):	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Child #2 SSN:	Child #2 Name (Last, First, MI)	Date of Birth (mm/dd/yyyy):	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Child #3 SSN:	Child #3 Name (Last, First, MI)	Date of Birth (mm/dd/yyyy):	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Child #4 SSN:	Child #4 Name (Last, First, MI)	Date of Birth (mm/dd/yyyy):	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Section 5: Signatures – Please submit this application to your Company Insurance Coordinator					
<ul style="list-style-type: none"> I understand that I am applying for optional vision 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 kehpc.ky.gov. 					
Employee Signature			Date		
IC/HRG Signature and Printed Name		Date	Telephone		