Anthem Customer Service

1.844.402.5347

**2026 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** | | | | | | | | | | | | |
| 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. | | | | | | | | | | | | | | | | | |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Employee Signature Date   |  |  |  | | --- | --- | --- | |  |  |  |   **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  IC/HRG Signature and Printed Name Date Telephone | | | | | | | | | | | | | | | | | |