**Wage Types 5681**

# Humana Vision Enrollment Form 2018

| Please complete the following information: | | | | |
|---|---|---|---|---|
| Social Security # | Last Name First Name MI | | | Date of Birth |
| Home Address | | | Contact Phone | Gender |
| City | State | ZIP Code | Business Phone | extension: |

| List All Your Eligible Dependents That Are To Be Covered | | |
|---|---|---|
| First MI Last | Sex | Date of Birth |
| Spouse: | M ☐ F ☐ | |
| Child: | M ☐ F ☐ | |
| Child: | M ☐ F ☐ | |
| Child: | M ☐ F ☐ | |
| Child: | M ☐ F ☐ | |
| Child: | M ☐ F ☐ | |

| # Dependents: | E-mail: | Payroll Clerk: | 1st Payroll Deduction |
|---|---|---|---|
| | | | |

| Company Name: | Company #: | Agent Code | Policy Effective Date: |
|---|---|---|---|
| | | 1024303 | 1/1/2018 |

## Please check your choice.

**HV130**

☐ Employee: $8.57
☐ Employee + One: $20.59
☐ Employee + Family $24.00

Send to :
Dennis Krol Insurance
P.O. Box 1818
Frankfort, KY 40602-1818
Or fax to : 502-875-3615
Or call : 800-467-5765, 502-875-3477
Email to : krolinsurance@bellsouth.net
Go Online : www.denniskrolinsurance.com

I wish to enroll in the plan indicated above as offered through my employer. I hereby authorize my employer to deduct all applicable contribution amounts from my salary or other compensation for the plan year, and for future renewal period(s). I understand that such contribution rate is subject to change on the anniversary date of the plan. I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

I understand that this is a minimum one (1) year contract.

Signature: X _____ Date: _____

***check paycheck for correct and timely deduction***

KYHJR6JEN