



# Enrollment/Change Form

Please print and complete all sections.

See instructions below.

Underwritten by Fidelity Security Life Insurance Company of  
Kansas City, Missouri

## EMPLOYER INFORMATION: To be Completed by Employer

<b>Group Number</b>	<b>Employer Name</b>				<b>Effective Date</b>
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## EMPLOYEE INFORMATION A: Add (enroll) T: Terminate C: Change (change of name, address or phone)

<input type="checkbox"/> <b>ADD</b>	<b>Sex</b> <input type="checkbox"/> M <input type="checkbox"/> F	<b>Member ID</b>	<b>Last Name (Employee or subscriber)</b>	<b>First Name</b>	<b>M.I.</b>	<b>Date of Birth</b>
<input type="checkbox"/> <b>TERM</b>						
<input type="checkbox"/> <b>CHG</b>						

<b>Social Security Number</b>	<b>Home Street Address</b>	<b>City/State/Zip</b>	<b>Home Phone</b> ( )
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## FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate C: Change (change of name)

<input type="checkbox"/> <b>A</b>	<b>Sex</b> <input type="checkbox"/> M <input type="checkbox"/> F	<b>Last Name (spouse)</b>	<b>First Name</b>	<b>M.I.</b>	<b>Date of Birth</b>	<b>Social Security Number</b>
<input type="checkbox"/> <b>T</b>						
<input type="checkbox"/> <b>C</b>						
<input type="checkbox"/> <b>A</b>	<b>Sex</b> <input type="checkbox"/> M <input type="checkbox"/> F	<b>Last Name (dependent)</b>	<b>First Name</b>	<b>M.I.</b>	<b>Date of Birth</b>	<b>Social Security Number</b>
<input type="checkbox"/> <b>T</b>						
<input type="checkbox"/> <b>C</b>						
<input type="checkbox"/> <b>A</b>	<b>Sex</b> <input type="checkbox"/> M <input type="checkbox"/> F	<b>Last Name (dependent)</b>	<b>First Name</b>	<b>M.I.</b>	<b>Date of Birth</b>	<b>Social Security Number</b>
<input type="checkbox"/> <b>T</b>						
<input type="checkbox"/> <b>C</b>						
<input type="checkbox"/> <b>A</b>	<b>Sex</b> <input type="checkbox"/> M <input type="checkbox"/> F	<b>Last Name (dependent)</b>	<b>First Name</b>	<b>M.I.</b>	<b>Date of Birth</b>	<b>Social Security Number</b>
<input type="checkbox"/> <b>T</b>						
<input type="checkbox"/> <b>C</b>						

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Instructions:

**Employer name:** Legal name of the employer.  
**Group Number:** Provided by EyeMed or EyeMed representative.  
**Location code:** Optional field for employers to track multiple locations.  
**Effective date:** Date set by employer in accordance with EyeMed proposal. Employer also sets effective date for new adds during contract period.

**Family Information:** List only eligible family members who are enrolling.  
 Dependent eligibility is the same as employer's health plan.  
**(A) Add:** Open (group) enrollment or new (individual) enrollment during the contract period.  
**(T) Terminate:** To terminate enrollment.  
**(C) Change:** A change of name, employee address or employee phone.

Once you elect EyeMed vision coverage, you cannot cancel for a 12-month period based upon your enrollment date. Deductions are adjusted according to payroll frequency.