



# 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

Group Number	Employer Name	Location Code	Division Code	Client Co Code	Effective Date
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## EMPLOYEE INFORMATION A: Add (enroll) T: Terminate C: Change (change of name, address or phone)

<input type="checkbox"/> ADD <input type="checkbox"/> TERM <input type="checkbox"/> CHG	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Member ID	Last Name (Employee or subscriber)	First Name	M.I.	Date of Birth
Social Security Number	Home Street Address		City/State/Zip		Home Phone ( )	

## FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate C: Change (change of name)

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

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.