



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 Emp Number	Employer Name	Date of Hire			Effective Date	
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
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.

Your Authorization:

I authorize vision plan payroll deduction for:

Per Employee only per month	\$.
Per Employee + 1 Dependent (spouse or child) per month	\$.
Per Employee + 2 or more Dependents per month	\$.

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. DO NOT RETURN THIS FORM TO EYEMED.