

Enrollment/Change Form

Please print and complete <u>all</u> sections. See instructions below.

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

EMPLOYER INFORMATION: To be Completed by Employer												
Group			Employer Name			Location Code Divis		sion Code		Client Co Code		Effective Date
Number												
EMPLOYEE INFORMATION A: Add (enroll) T: Terminate												
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						subscriber)		riistivaine			141.1.	Date of Birth
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шсн												
Social Security			Home Street Addre			ess		City/State/Zip				Home Phone
Number												()
FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate												
C: Change (change of name)												
$\Box \mathbf{A}$			Last	ast Name (spouse)		First Name		M.I.	M.I. Date of Bir			
	\square M										Nur	nber
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	Sex		Last Name (dependent)			First Name		M.I. Date		ate of Birth Soc		ial Security
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$\Box \mathbf{C}$	□F											
□A	Sex		Last Name (dependent)			First Name		M.I. Date of		te of Birtl	irth Social Security	
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$\square \mathbf{A}$	Sex		Last Name (dependent)		lent)	First Name		M.I. D				ial Security
											Number	
□С	□F											
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.