Enrollment/Change Form

Please print in all capital letters using blue or black ink. Please complete all sections.
Required sections are marked with an *.
Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri

Employer Information: to be completed by Employer

Employer Name*

Effective Date*^

[ ] / [ ] / [ ]

^Date set by employer in accordance with EyeMed proposal. Employer also sets effective date for new adds during contract period.

Group Number*

Subgroup*

Location Code

Employee Information: to be completed by Employee

Change Type*: [ ] Add   [ ] Term   [ ] Update   Member ID:

Last Name*

Date of Birth* [ ] / [ ] / [ ]

First Name*   MI   **Gender*** [ ] Male [ ] Female   **Phone Number** ( ) -

Street Address*

City*   **State***   **Zip Code***   **Social Security Number*^** - -

Employee Email Address:

^Last four digits of Employee's Social Security Number are required.

Family Information: to be completed by Employee. Only eligible dependents may be enrolled.

Dependent 1
Change Type*: [ ] Add   [ ] Term   [ ] Update
Relationship*: [ ] Husband [ ] Wife [ ] Son [ ] Daughter [ ] Domestic Partner
Last Name*   **Gender*:** [ ] Male [ ] Female
First Name*   MI   Social Security Number - -   Date of Birth* [ ] / [ ] / [ ]

Dependent 2
Change Type*: [ ] Add   [ ] Term   [ ] Update
Relationship*: [ ] Husband [ ] Wife [ ] Son [ ] Daughter [ ] Domestic Partner
Last Name*   **Gender*:** [ ] Male [ ] Female
First Name*   MI   Social Security Number - -   Date of Birth* [ ] / [ ] / [ ]

Dependent 3
Change Type*: [ ] Add   [ ] Term   [ ] Update
Relationship*: [ ] Husband [ ] Wife [ ] Son [ ] Daughter [ ] Domestic Partner
Last Name*   **Gender*:** [ ] Male [ ] Female
First Name*   MI   Social Security Number - -   Date of Birth* [ ] / [ ] / [ ]

Dependent 4
Change Type*: [ ] Add   [ ] Term   [ ] Update
Relationship*: [ ] Husband [ ] Wife [ ] Son [ ] Daughter [ ] Domestic Partner
Last Name*   **Gender*:** [ ] Male [ ] Female
First Name*   MI   Social Security Number - -   Date of Birth* [ ] / [ ] / [ ]

Employee Signature*: _____   **Date*:** [ ] / [ ] / [ ]

For additional dependents, please complete a second form.