



# 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\*

Phone Number

Male

Female

(

-

-  -

Street Address\*

City\*

State\*

Zip Code\*

Social Security Number\*^

-  -

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

Employee Email Address:

## 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\*:  /  /