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*^ - -

^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*: / /

For additional dependents, please complete a second form.