

Enrollment/Change Form Please print and complete all sections. See instructions below.

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

EMDLO	VED	MEC	DM/	TION: To be Co	male	ted by Employe	r					
Group			Employer Name		, inpid	Location Code Divi		ion Code	Client Co	Code	Effective Date	
Number												
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EMPLOYEE INFORMATION A: Add (enroll) T: Terminate C: Change (change of name, address or phone)												
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Social S		ity	Home Street Addr			ess		City/atate/zip			()	
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FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate												
C: Change (change of name)												
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Employee Signature												
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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.