

## Enrollment/Change Form

Please print and complete all sections. See instructions below.

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

## MTRS RETIREE

EMPLOYER INFORMATION: To be Completed by Employer    Location Code   Division Code   Client Co Code   Effective Date												
Group			Employer Name		Lo	Location Code Di		sion Code	Citent Co	Coue	Ellective pare	
Number			TOURI OF WEVMOUTH									
9845751			TOWN OF WEYMOUTH									
EMPLOYEE INFORMATION A: Add (enroll) T: Terminate C: Change (change of name, addre										Date of Birth		
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Social S		rity		Home Street Addre		<b>?</b> \$\$		City/Ota	(C) <u>L</u> ip		( )	
Numbe	Г											
Terminate												
FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate												
C: Change (change of name)											ial Security	
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DA	Sex		Last Name (dependent)			First Name		M.I.	Date of Birth		Social Security Number	
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ПC												
Date:												
Employee Signature: Date: 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

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.

## PLAN CHOICE: BASIC VISION ENHANCED VISION