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.