



# 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**		
Group Number*	Subgroup*				
Location Code					

\*\*Date set by employer in accordance with EyeMed proposal. Employer also sets effective date for new adds during contract period.

## Employee Information: to be completed by Employee

<b>Change Type*:</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Update	Member ID:					
Last Name*				Date of Birth*		
First Name*	MI	Gender*	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.

<b>Dependent 1</b>	<b>Change Type*:</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Update	Relationship*:	<input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Domestic Partner
Last Name*			Gender*: <input type="checkbox"/> Male <input type="checkbox"/> Female
First Name*	MI	Social Security Number	Date of Birth*
Dependent 2			
<b>Dependent 2</b>	<b>Change Type*:</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Update	Relationship*:	<input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Domestic Partner
Last Name*			Gender*: <input type="checkbox"/> Male <input type="checkbox"/> Female
First Name*	MI	Social Security Number	Date of Birth*
Dependent 3			
<b>Dependent 3</b>	<b>Change Type*:</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Update	Relationship*:	<input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Domestic Partner
Last Name*			Gender*: <input type="checkbox"/> Male <input type="checkbox"/> Female
First Name*	MI	Social Security Number	Date of Birth*
Dependent 4			
<b>Dependent 4</b>	<b>Change Type*:</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Update	Relationship*:	<input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Domestic Partner
Last Name*			Gender*: <input type="checkbox"/> Male <input type="checkbox"/> Female
First Name*	MI	Social Security Number	Date of Birth*

Employee Signature\*: \_\_\_\_\_

Date\*: [ ] / [ ] / [ ]