



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**
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Group Number*	Subgroup*
<input type="text"/>	<input type="text"/>
Location Code	
<input type="text"/>	

**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

Change Type*: <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Update	Member ID:		
<input type="text"/>	<input type="text"/>		
Last Name*	Date of Birth*		
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>		
First Name*	MI	Gender* <input type="checkbox"/> Male <input type="checkbox"/> Female	Phone Number
<input type="text"/>	<input type="text"/>	<input type="text"/>	(<input type="text"/>) <input type="text"/> - <input type="text"/>
Street Address*			
<input type="text"/>			
<input type="text"/>			
City*	State*	Zip Code*	Social Security Number**
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>
Employee Email Address:			
<input type="text"/>			

**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*: <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		
<input type="text"/>	<input type="text"/>		
First Name*	MI	Social Security Number	Date of Birth*
<input type="text"/>	<input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Dependent 2	Change Type*: <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		
<input type="text"/>	<input type="text"/>		
First Name*	MI	Social Security Number	Date of Birth*
<input type="text"/>	<input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Dependent 3	Change Type*: <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		
<input type="text"/>	<input type="text"/>		
First Name*	MI	Social Security Number	Date of Birth*
<input type="text"/>	<input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Dependent 4	Change Type*: <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		
<input type="text"/>	<input type="text"/>		
First Name*	MI	Social Security Number	Date of Birth*
<input type="text"/>	<input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

Employee Signature*: _____

Date*: / /

For additional dependents, please complete a second form.