# 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*^ - -

^Last four digits of Employee's Social Security Number are required.

Employee Email Address:

## 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.