



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

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.