



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.