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*: T o w n o f c l i n t o n

Effective Date*^: ___ / ___ / ____

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

Group Number*: 1 0 1 1 2 4 1 1 0 0 1

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.