



Enrollment/Change Form

Please print and complete all sections.

See instructions below.

Underwritten by Fidelity Security Life Insurance Company of
Kansas City, Missouri

EMPLOYER INFORMATION: To be Completed by Employer

Group Number 9771221	Employer Name Cross Church	Location Code	Division Code N/A	Client Co Code N/A	Effective Date 01/01/2026
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EMPLOYEE INFORMATION A: Add (enroll) T: Terminate C: Change (change of name, address or phone)

☐ ADD ☐ TERM ☐ CHG	Sex ☐ M ☐ F	Member ID N/A	Last Name (Employee or subscriber)	First Name	M.I.	Date of Birth
Social Security Number		Home Street Address		City/State/Zip		Home Phone ()

FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate C: Change (change of name)

☐ A ☐ T ☐ C	Sex ☐ M ☐ F	Last Name (spouse)	First Name	M.I.	Date of Birth	Social Security Number
☐ A ☐ T ☐ C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number
☐ A ☐ T ☐ C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number
☐ A ☐ T ☐ C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number
☐ A ☐ T ☐ C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number

Employee Signature: _____ Date: _____

Instructions:

Employer name: Legal name of the employer.

Group Number: Provided by EyeMed or EyeMed representative.

Location code: Optional field for employers to track multiple locations.

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

Family Information: List only eligible family members who are enrolling.

Dependent eligibility is the same as employer's health plan.

(A) Add: Open (group) enrollment or new (individual) enrollment during the contract period.

(T) Terminate: To terminate enrollment.

(C) Change: A change of name, employee address or employee phone.

Your Authorization:

I authorize vision plan payroll deduction for:

Per Employee only per month	\$ 4.99
Per Employee + 1 per month	\$ 9.43
Subscriber + Family	\$13.88

Once you elect EyeMed vision coverage, you cannot cancel for a 12 month period based upon your enrollment date. Deductions are adjusted according to payroll frequency. I understand that future rates for **48 month** renewal of this plan will be negotiated between my employer and EyeMed Vision Care.