



# 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	Employer Name	Location Code	Division Code	Client Co Code	Effective Date
<b>9771239</b>	<b>Shiloh Christian School</b>	N/A	N/A	N/A	01/01/2025

## EMPLOYEE INFORMATION A: Add (enroll) T: Terminate C: Change (change of name, address or phone)

<input type="checkbox"/> ADD <input type="checkbox"/> TERM <input type="checkbox"/> CHG	Sex <input type="checkbox"/> M <input type="checkbox"/> 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)

<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (spouse)	First Name	M.I.	Date of Birth	Social Security Number
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> 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	\$ 0.00
Per Employee + 1 per month	\$ 4.44
Subscriber + Family	\$ 8.89

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.