



Enrollment/Change Form

Please print and complete all sections. See instructions below.

EMPLOYER INFORMATION

| | | | | |
|---------------------|----------------------|-----------------------------|-----------------------------|-----------------------|
| Group Number | Employer Name | Location Code N/A | Division Code N/A | Effective Date |
|---------------------|----------------------|-----------------------------|-----------------------------|-----------------------|

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 | 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 |
| <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.