

Enrollment/Change Form Please print and complete <u>all</u> sections.

See instructions below.

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

| EMPLOYER INFORMATION: To be Completed by Employer | | | | | | | | | | | | | |
|--|-------------|-------------|------------------------------|---|-------|---------------------------|--|----------------|--------------------|-------------------|-----|----------------------|--|
| Group | | | Employer Name | | | Location Code Divi | | ision Code | | Client Co Code | | Effective Date | |
| Number | | | | | | | | ļ | | | | | |
| | | | Sherman College | | | | | | | | | | |
| EMPLOYEE INFORMATION A: Add (enroll) T: Terminate | | | | | | | | | | | | ess or phone) | |
| □ADD Sex | | Sex | | | | st Name (Employee | | First Name | | M.I. | | Date of Birth | |
| | | \square M | or or | | or s | subscriber) | | | | | | | |
| □CHG □ I | | □ F | | | | | | | | | | | |
| Cocial Conveits | | | Home Street Addr | | ddaa | MOGG | | City/State/Zip | | 7: | | Home Phone | |
| Social Security Number | | | Home Street Addr | | | 633 | | City/State/Zip | | zip | | () | |
| rumber | | | | | | | | | | | | | |
| FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate | | | | | | | | | | | | | |
| C: Change (change of name) | | | | | | | | | | | | | |
| □A | Sex | | Last Name (spouse) | | | First Name | | M.I. | M.I. Date of Birth | | Soc | Social Security | |
| $\Box \mathrm{T}$ | \square M | | - - | | | | | | | | Nur | nber | |
| □С | | | | | | | | | | | | | |
| $\Box \mathbf{A}$ | Sex | | Last Name (dependent) | | | First Name | | M.I. | D | ate of Birth | | ial Security | |
| ПТ | | | | | | | | | | | Nur | nber | |
| ПС | □ F | | Lost Nomes (describer) | | | First Name | | N/L T | | CD'I | | ? -1 C ! : | |
| □A □T | | | Last Name (dependent) | | | First Name | | M.I. | D | ate of Birth | | ial Security nber | |
| □C | | | | | | | | | | | Nui | iiber | |
| | Sex | | Last Name (dependent) | | | First Name | | M.I. D | | oate of Birth Soc | | ial Security | |
| | | | Last Name (acpendent) | | | T II St I valle | | | | | | nber | |
| \Box C | □F | | | | | | | | | | | | |
| \Box A | Sex | | Last Name (dependent) | | | First Name | | M.I. D | | | | ial Security | |
| $\square \mathrm{T}$ | \square M | | | | | | | | | | Nur | nber | |
| □С | □F | | | | | | | | | | | | |
| | Sex | | Last Name (dependent) | | lent) | First Name | | M.I. D | | | | ial Security | |
| □T □ M □ F | | L | | | | | | | | | Nur | nber | |
| | _ _ | | | _ | | | | | | | | _ | |
| | | | | | | | | | | | | | |
| 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.