# 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 Combined Insurance Company of America
New York Residents only: Combined Life Insurance Company of New York
The Certificate of Insurance is on file with your employer. Contact your employer to review a copy of the Certificate.

## Employer Information: to be completed by Employer

Employer Name*

Effective Date*^ ___ / ___ / ____

Group Number*

Subgroup*

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

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*^ ___ - ___ - ____

Employee Email Address:

^Last four digits of Employee's Social Security Number are required

## 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.