



Enrollment/Change Form

Please print and complete all sections.
See instructions below.

Group Number	Employer Name	Location Code	Division Code	Client Co Code	Effective Date
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SUBSCRIBER INFORMATION A: Add (enroll)						
<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 (Subscriber)	First Name	M.I.	Date of Birth
SSN	Home Street Address			City/State/Zip		Home Phone ()

FAMILY INFORMATION (Only those eligible may be enrolled.)						
<input type="checkbox"/> ADD <input type="checkbox"/> TERM <input type="checkbox"/> CHG	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (spouse)	First Name	M.I.	Date of Birth	SSN
<input type="checkbox"/> ADD <input type="checkbox"/> TERM <input type="checkbox"/> CHG	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	SSN
<input type="checkbox"/> ADD <input type="checkbox"/> TERM <input type="checkbox"/> CHG	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	SSN
<input type="checkbox"/> ADD <input type="checkbox"/> TERM <input type="checkbox"/> CHG	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	SSN
<input type="checkbox"/> ADD <input type="checkbox"/> TERM <input type="checkbox"/> CHG	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	SSN

Subscriber Signature: _____ Date: _____

Instructions:

Plan name: Legal name of the plan.
Group Number: Provided by EyeMed or EyeMed representative.
Location code: Optional field for employers 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 subscriber'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, address or phone.

Attention Benefit Administrators:

This enrollment card has been provided to assist you in capturing member information for electronic data submission to EyeMed. EyeMed does not accept these hard copy enrollment cards for member adds, changes, or deletions.

Your Authorization:

I authorize vision plan payroll deduction for:
 Per Employee only per month
 Per Employee + 1 per month
 Per Employee + Family per month

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 24 month renewal of this plan will be negotiated between my employer and EyeMed Vision Care