



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 9713249	Employer Name STATE OF IOWA VOL VIS - ICP	Department #	Payroll #	Effective Date
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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
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Social Security Number	Home Street Address	City/State/Zip	Home Phone ()
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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:

Subscriber	\$10.04
Subscriber + Spouse	\$18.62
Subscriber + Child(ren)	\$19.14
Subscriber + Family	\$27.50

Send Form or Fax to:

Two Rivers Insurance Services
 214 N. Main Street
 P.O. Box 746
 Burlington, IA 52601
 Fax: 319-758-8521

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.