



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

Location Code  Division 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.