

## Enrollment/Change Form Please print in all capital letters using blue or black ink. Please complete all sections.

Required sections are marked with an  $^{\star}$ .

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*		1 1 1 1			Effective Date*^
Group Number*		Sı	ubgroup*		^Date set by employer in accordance with EyeMed
					proposal. Employer also sets effective date for new adds
Location Code					during contract period.
Employee Inform	<b>nation</b> : to be comple	ted by Employe	е		
Change Type*:	☐ Add ☐ T	erm 🔲 U	pdate Memb	er ID:	
Last Name*					Date of Birth*
					/ /
First Name*			MI Gender*	Pho	one Number
			☐ Male ☐	Female (	)
Street Address*					
	<del></del>	***		+++++	
City*			State*	Zip Code*	Social Security Number*^
Employee Email A	ddress:			^Last fou	ur digits of Employee's Social Security Number are required.
Family Information: to be completed by Employee. Only eligible dependents may be enrolled.					
Family Informat					
Dependent 1	Change Type*:	Add	☐ Term ☐ Update		
	Relationship*:	☐ Husband	☐ Wife ☐ Son [	□ Daughter □ I	Domestic Partner
Last Name*		1 1 1 1			Gender*:
					Male Female
First Name*			MI Social Security N	umber	Date of Birth*
					/ / /
Dependent 2	Change Type*:	☐ Add	☐ Term ☐ Update	9	
Dependent 2	Relationship*:	☐ Husband	☐ Wife ☐ Son [	☐ Daughter ☐ I	Domestic Partner
Last Name*					Gender*:
					☐ Male ☐ Female
First Name*			MI Social Security N	umber	Date of Birth*
					1 1
	Change Type*:	☐ Add	☐ Term ☐ Update		
Dependent 3	Relationship*:	☐ Husband			Domestic Partner
Last Name*	Relationship .	III Hasbana	L Wile L Soil L	_ baagintei i	Gender*:
					☐ Male ☐ Female
First Name*			MI Social Security N	umbor	Date of Birth*
Tilstraille	T T T T T T		30clar Security N	umber	
					/ / /
Dependent 4	Change Type*:	☐ Add	☐ Term ☐ Update		
	Relationship*:	☐ Husband	☐ Wife ☐ Son [	☐ Daughter ☐ I	Domestic Partner
Last Name*					Gender*:
					☐ Male ☐ Female
First Name*			MI Social Security N	umber	Date of Birth*
				-	/ / /
Employee Signatu	re*:			Date	e*: / /