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*^ (- -)

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

Employee Email Address:

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.