# 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*: Colonial School District

Effective Date*^: / /

Group Number*: 1011440

Subgroup*: 1004

Class: 1004

Plan: 10000001

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

Location Code: not applicable

Division Code: not applicable

## Employee Information: to be completed by Employee

Change Type*: ☐ Add ☐ Term ☐ Update

Member ID: 000

Last Name*

Date of Birth*: / /

First Name*

MI

Gender*: ☐ Male ☐ Female

Phone Number: ( ) -

Street Address*

City*

State*

Zip Code*

Social Security Number*^: 000 - -

^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: XXX - XX - XXXX

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: XXX - XX - XXXX

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: XXX - XX - XXXX

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.