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 Fidelity Security Life Insurance Company of Kansas City, Missouri

Employer Information: to be completed by Employer

Employer Name*
American Library Association

Effective Date*^
□□ / □□ / □□□□

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

Group Number*
1 0 0 7 5 3 3

Subgroup*
1 0 0 1

Location 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.