Enrollment/Change Form

Please print and complete all sections.
See instructions below.

EyeMed VISION CARE®

The Certificate of Insurance is on file with your employer. Contact your employer to review a copy of the Certificate.

Underwritten by Combined Insurance Company of America
New York Residents only: Combined Life Insurance Company of New York

EMPLOYER INFORMATION: To be Completed by Employer

Group Number	Employer Name	Location Code	Division Code	Client Co Code	Effective Date
9873241	Cape Cod Municipal Health Group	N/A	N/A	N/A	

EMPLOYEE INFORMATION A: Add (enroll) T: Terminate C: Change (change of name, address or phone)

☐ADD ☐TERM ☐CHG	Sex ☐ M ☐ F	Member ID	Last Name (Employee or subscriber)	First Name	M.I.	Date of Birth

Social Security Number	Home Street Address	City/State/Zip	Home Phone ( )

FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate C: Change (change of name)

☐A ☐T ☐C	Sex ☐ M ☐ F	Last Name (spouse)	First Name	M.I.	Date of Birth	Social Security Number
☐A ☐T ☐C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number
☐A ☐T ☐C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number
☐A ☐T ☐C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number
☐A ☐T ☐C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number

Employee Signature: _____ Date: _____

Employer Signature: _____ Date: _____

Monthly Rates	
Employee Only	***$7.53***
Employee + 1	***$14.31***
Employee + Family	***$21.02***

Instructions:

Employer name: Legal name of the employer.
Group Number: Provided by EyeMed or EyeMed representative.
Location code: Optional field for employers to track multiple locations.
Effective date: Date set by employer in accordance with EyeMed proposal. Employer also sets effective date for new adds during contract period.

Family Information: List only eligible family members who are enrolling.
Dependent eligibility is the same as employer's health plan.
(A) Add: Open (group) enrollment or new (individual) enrollment during the contract period.
(T) Terminate: To terminate enrollment.
(C) Change: A change of name, employee address or employee phone.

Your Authorization:

I authorize vision plan payroll deduction. Once you elect EyeMed vision coverage, you cannot cancel for a 12-month period based upon your enrollment date. Deductions are adjusted according to payroll frequency.

Please Return Form to Your Employer's Benefit Office by Your Open Enrollment Due Date. Do Not Return It To EyeMed.