



# Enrollment/Change Form

Please print and complete **all** sections.

See instructions below.

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

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)

<input type="checkbox"/> ADD	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Member ID	Last Name (Employee or subscriber)	First Name	M.I.	Date of Birth
<input type="checkbox"/> TERM						
<input type="checkbox"/> CHG						
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)

<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (spouse)	First Name	M.I.	Date of Birth	Social Security Number
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number

Employee 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.**