Enrollment/Change Form

EMAIL TO: HRBENEFITS@LOWELLMA.GOV

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*

Effective Date*^

/ /

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

Group Number*

Subgroup*

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*   Phone Number

☐ Male ☐ Female   ( ) –

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.