# 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*: Town of Lynnfield

Effective Date*^: / /

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

Group Number*: 1011525

Subgroup*: 1001

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.