



STATE OF IOWA EMPLOYEES

ENROLLMENT/CHANGE FORM

Please print and complete all sections. See instructions below.

Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri

FOR BEST RESULTS: Download this pdf and complete by using Adobe Acrobat Reader.

EMPLOYER INFORMATION: To be Completed by Employer

Group Number 9713249 | State of Iowa Employees | State of Iowa Voluntary Vision Plan

Effective Date _____ Other _____

Dept # _____

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

Employee information form with fields for Sex, Last Name, First Name, M.I., Date of Birth, Date of Hire, Social Security #, Home Phone, Home Street Address, City, State, Zip.

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

Family information form with multiple rows for spouse and dependents, including fields for Sex, Last Name, First Name, M.I., and Date of Birth.

Employee Signature _____ Date _____

INSTRUCTIONS:

- Employer name: Legal name of the employer.
Group Number: Provided by carrier.
Effective date: Date set by employer in accordance with EyeMed proposal.
Family Information: List only eligible family members who are enrolling.
(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:

Table with 2 columns: Authorization description and amount. Rows include Per Employee only per month (\$9.48), Per Employee + spouse per month (\$17.68), Per Employee + child(ren) per month (\$18.16), and Per Employee + family per month (\$25.96).

SEND FORM OR FAX TO:

Two Rivers Insurance Services
4500 Westown Parkway Suite 150
West Des Moines, IA 50266
Fax: 515-327-2021

IMPORTANT: if clicking, "submit", you must first download this form.