

Enrollment / Change Form

Please print & Complete all sections.

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



EMPLOYER INFORMATION: To be Completed by Employer

Group Number 9815218	Employer Name Matrix Employer Services	Location Code	Division Code NA	Client Co Code NA	Effective Date (the 1 st of the month)
--------------------------------	--	----------------------	----------------------------	-----------------------------	---

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

<input type="checkbox"/> ADD <input type="checkbox"/> TERM <input type="checkbox"/> CHG	Sex <input type="checkbox"/> M <input type="checkbox"/> 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)

<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	SSN
<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	SSN
<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	SSN
<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	SSN
<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	SSN

Your Authorization:

I authorize vision plan payroll deduction for:

- | | | | |
|--|---------|--|---------|
| <input type="checkbox"/> Per Employee only per month | \$ 6.40 | <input type="checkbox"/> Per Employee + child(ren) per month | \$12.80 |
| <input type="checkbox"/> Per Employee + spouse per month | \$12.16 | <input type="checkbox"/> Per Employee + family per month | \$18.81 |

Employee Signature: _____ Date: _____

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.

