



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 Fidelity Security Life Insurance Company of Kansas City, Missouri

Employer Information: to be completed by Employer

Employer Name* **VOLUNTEER & EXEMPT FIREMAN'S** Effective Date** **01/01/2026**

Group Number* Subgroup* **BENEVOLENT ASSOCIATION OF VALHALLA**

Location Code

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

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* _____

Employee Email Address: _____ ^Last four digits of Employee's Social Security Number are required.

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.