



Enrollment/Change Form

Please print and complete all sections.
See instructions below.

The Certificate of Insurance is on file with your employer. Contact your employer to review a copy of the Certificate.

Underwritten by Combined Insurance Company of America
New York Residents only: Combined Life Insurance Company of New York

EMPLOYER INFORMATION: To be Completed by Employer

Group Number	Employer Name	Location Code	Division Code	Client Co Code	Effective Date
9873241	Cape Cod Municipal Health Group	N/A	N/A	N/A	

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	Social Security Number
<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	Social Security Number
<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	Social Security Number
<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	Social Security Number
<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	Social Security Number

Employee Signature: _____ Date: _____

Employer Signature: _____ Date: _____

Monthly Rates	
<i>Employee Only</i>	\$7.53
<i>Employee + 1</i>	\$14.31
<i>Employee + Family</i>	\$21.02

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.

Your Authorization:

I authorize vision plan payroll deduction. 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.