



# Enrollment/Change Form

Please print and complete all sections.

See instructions below.

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

## EMPLOYER INFORMATION: To be Completed by Employer

<b>Group Number</b>	<b>Employer Name</b>	<b>Effective Date</b>
9812363	State of Delaware	

## PENSIONER 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	<b>Gender</b> <input type="checkbox"/> M <input type="checkbox"/> F	<b>Employee ID</b>	<b>Last Name (Pensioner or subscriber)</b>	<b>First Name</b>	<b>M.I.</b>	<b>Date of Birth</b>
<b>Social Security Number</b>	<b>Home Street Address</b>		<b>City/State/Zip</b>		<b>Home Phone ( )</b>	

## FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate C: Change (change of name) \*\*Relationship of Spouse applies to Spouse or Civil Union Spouse \*\*Relationship of Dependent applies to Dependent(s) and/or Civil Union Dependent(s)

<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	<b>Gender</b> <input type="checkbox"/> M <input type="checkbox"/> F	<b>Last Name (spouse)</b>	<b>First Name</b>	<b>M.I.</b>	<b>Date of Birth</b>
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	<b>Gender</b> <input type="checkbox"/> M <input type="checkbox"/> F	<b>Last Name (dependent)</b>	<b>First Name</b>	<b>M.I.</b>	<b>Date of Birth</b>
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	<b>Gender</b> <input type="checkbox"/> M <input type="checkbox"/> F	<b>Last Name (dependent)</b>	<b>First Name</b>	<b>M.I.</b>	<b>Date of Birth</b>
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	<b>Gender</b> <input type="checkbox"/> M <input type="checkbox"/> F	<b>Last Name (dependent)</b>	<b>First Name</b>	<b>M.I.</b>	<b>Date of Birth</b>
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	<b>Gender</b> <input type="checkbox"/> M <input type="checkbox"/> F	<b>Last Name (dependent)</b>	<b>First Name</b>	<b>M.I.</b>	<b>Date of Birth</b>

**Pensioner Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### Instructions:

**Effective date:** Beginning date of coverage.

**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 Pensioner name, address or phone

### Your Authorization:

I authorize vision plan payroll deduction for:

Pensioner Only	\$ 6.12 per month
Pensioner + Spouse	\$ 9.64 per month
Pensioner + Child(ren)	\$ 9.84 per month
Pensioner + Family	\$15.88 per month

The vision plan is a binding election. Once enrolled, you may not drop coverage during the plan year.

Please note: The enrollment form is for the Pension Office's use only and will not be used for any external purpose.