



CHANGE / TERMINATE FORM

FIDELITY SECURITY LIFE INSURANCE COMPANY
 Kansas City, Missouri

CHANGE MEMBERSHIP	
<input type="checkbox"/> ADDRESS CHANGE <input type="checkbox"/> NAME CHANGE <input type="checkbox"/> TELEPHONE CHANGE <input type="checkbox"/> DATE OF BIRTH CORRECTION <input type="checkbox"/> MARRIAGE _____ (DATE) <input type="checkbox"/> NEWBORN _____ (DATE)	<input type="checkbox"/> ADOPTION _____ (DATE) <input type="checkbox"/> JOB CHANGE _____ (DATE) <input type="checkbox"/> DIVORCE _____ (DATE) <input type="checkbox"/> SEPARATION _____ (DATE) <input type="checkbox"/> DEATH _____ (DATE) <input type="checkbox"/> OTHER _____ (EXPLAIN) _____ (DATE)

EMPLOYER SECTION (TO BE COMPLETED BY EMPLOYER)			
EMPLOYER NAME	EMPLOYEE DATE OF HIRE	EMPLOYEE DATE OF COVERAGE	EMPLOYEE TERMINATION OF COVERAGE

EMPLOYEE SECTION						
* SOCIAL SECURITY #	LAST NAME	FIRST NAME	M.I.	MARITAL STATUS	GENDER	D.O.B.
				<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
MAILING ADDRESS		CITY, STATE AND ZIP CODE			CONTACT PHONE #	
	CITY	STATE	ZIP			
				TYPE OF COVERAGE REQUESTED		
				<input type="checkbox"/> EMPLOYEE <input type="checkbox"/> EMPLOYEE + 1 <input type="checkbox"/> EMPLOYEE + 2 OR MORE (FAMILY)		

ADD OR TERMINATE DEPENDENTS TO BE COVERED							
LAST NAME	FIRST NAME	M.I.	RELATIONSHIP	DATE OF BIRTH	GENDER	SOCIAL SECURITY #	ADD / CHANGE OR TERMINATE
			<input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		<input type="checkbox"/> ADD/CHANGE <input type="checkbox"/> TERM DATE
			<input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		<input type="checkbox"/> ADD/CHANGE <input type="checkbox"/> TERM DATE
			<input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		<input type="checkbox"/> ADD/CHANGE <input type="checkbox"/> TERM DATE
			<input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		<input type="checkbox"/> ADD/CHANGE <input type="checkbox"/> TERM DATE
			<input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		<input type="checkbox"/> ADD/CHANGE <input type="checkbox"/> TERM DATE
			<input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		<input type="checkbox"/> ADD/CHANGE <input type="checkbox"/> TERM DATE
			<input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		<input type="checkbox"/> ADD/CHANGE <input type="checkbox"/> TERM DATE

ANY OTHER VISION COVERAGE		
NAME OF OTHER INSURANCE COMPANY	NAME OF SUBSCRIBER	GROUP OR POLICY ID #

Employee to fill in the sections marked by the [Pencil] icon only. Please sign and date form before submitting.

<ul style="list-style-type: none"> I hereby certify that all information furnished is true to the best of my knowledge. I request group vision coverage for which I am or may become eligible If health care is provided by a participating provider, all benefits will be paid directly to the provider by OPTICARE VISION PLANS 	<ul style="list-style-type: none"> I authorize the release of records or other information pertaining to the vision care services provided to me and my dependents covered on this form by OptiCare Vision Plans providers or other vision providers for the purpose of providing administrative services with OptiCare Vision Plans.
Signature	Date