Enrollment/Change Form

Please print and complete all sections.
See instructions below.

Underwritten by Combined Insurance Company of America
New York Residents only: Combined Life Insurance Company of New York
The Certificate of Insurance is on file with your employer. Contact your employer to review a copy of the Certificate.

EMPLOYER INFORMATION: To be Completed by Employer

Group Number	Employer Name	Location Code	Division Code	Client Co Code	Effective Date
9874934	OMCE	N/A	N/A	N/A	

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

☐ADD ☐TERM ☐CHG	Sex ☐ M ☐ F	Member ID	Last Name (Subscriber)	First Name	M.I.	Date of Birth
		N/A				

Social Security No.	Home Street Address	City/State/Zip	Home Phone ( )

SPOUSE INFORMATION (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate C: Change (change of name)

	Sex ☐ M ☐ F	Last Name (Spouse)	First Name	M.I.	Date of Birth	Social Security No.

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.

Please make payment payable to:
Upstate Benefit Planning LLC
And send your enrollment to us at:

Upstate Benefit Planning LLC
PO Box 1476
Latham NY 12110

Contact: Trisha Hollister
518-505-7901

Please indicate future billing preference:

Member Only:
Quarterly: $23.07 ***Annual: $92.28***

Member & Spouse:
Quarterly: $38.34 ***Annual $153.36***