



# 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**

Group Number	Employer Name <b>Innovative Employee Solutions</b>	Location Code	Effective Date
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**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	Employee Last Name:	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:** \_\_\_\_\_

By signing above, I have chosen to participate in **IES'** Section 125 plan, and I understand that my vision care premiums listed below will be deducted on a pre-tax basis as established under this plan (unless otherwise noted or required). I furthermore understand that as a participant in this plan, I will not be able to cancel my selected coverage(s) until next year's open enrollment.

**ELIGIBILITY: Employees must work 20 hours/week on a minimum 3 month assignment. EFFECTIVE DATE: First of the month following 30 days of employment or during open enrollment.**

Return the completed form to IES by FAX at 858-715-5110 or email to [jmaynard@innovative-es.com](mailto:jmaynard@innovative-es.com). Please contact IES Benefits with any questions at 858-300-2753.

Employee Only Cost	\$1.49 per week
Employee + Spouse	\$2.82 per week
Employee + Children	\$2.97 per week
Employee + Family	\$4.38 per week

Deductions are adjusted according to payroll frequency.