6368 Pearl Road
Main Floor
Cleveland, OH 44130

Phone: 440-842-9922
800-788-8146
Fax: 440-842-8669

Email: itenrollment@insurancestrategyinc.com
Website: insurancestrategyinc.com
Facebook: facebook.com/insurancestrategy

Employee Enrollment / Change Application

Reason for Application

☐ New Enrollment
☐ Open Enrollment
☐ Address Change
☐ Add Dependent to Policy
☐ Delete Dependent from Policy
☐ Name Change
☐ Waiver

☐ Qualifying Event (please complete date and reason)

Event Date: ______________________

☐ Marriage ☐ Divorce
☐ Birth of Child ☐ Adoption
☐ Termed Employment ☐ Other

☐ COBRA

Event: _________ Date: ____________

Date of Hire: ______________________________

Plan Information (please select one per row)

Design:	☐ Signature Series	☐ Choice Series WITH Lens Options	☐ Choice Series WITHOUT Lens Options
Coverage:	☐ Plan A	☐ Plan B	☐ Plan C	☐ Exam Plus (Signature only)
Level:	☐ Employee	☐ Employee + 1	☐ Family

Employee Information

Last Name	First Name	MI	Gender ☐ M ☐ F
Home Address	City	State	Zip
Social Security #	Date of Birth	Home Phone #	
Employer Name		Employment Status: ☐ Active ☐ Retired ☐ Disabled ☐ Other: _________	
Job Title			

List Dependents

Relationship	First Name	Last Name	Date of Birth	Social Security #	Gender	Student
Spouse					☐ M ☐ F	
☐ Child ☐ Adopted ☐ Stepchild ☐ Other					☐ M ☐ F	☐ Y ☐ N
☐ Child ☐ Adopted ☐ Stepchild ☐ Other					☐ M ☐ F	☐ Y ☐ N
☐ Child ☐ Adopted ☐ Stepchild ☐ Other					☐ M ☐ F	☐ Y ☐ N
☐ Child ☐ Adopted ☐ Stepchild ☐ Other					☐ M ☐ F	☐ Y ☐ N
☐ Child ☐ Adopted ☐ Stepchild ☐ Other					☐ M ☐ F	☐ Y ☐ N

Coordination of Benefits

Are you or any other member(s) of your family covered by any other plan providing vision benefits?

_____ Yes _____ No

Relationship	Individual with Other Coverage	Carrier Name	Employer Name	Type of Coverage
Spouse				
☐ Child ☐ Adopted ☐ Stepchild ☐ Other				
☐ Child ☐ Adopted ☐ Stepchild ☐ Other				
☐ Child ☐ Adopted ☐ Stepchild ☐ Other				

Employee Signature

I hereby apply or decline to participate in group coverage. I understand I may or may not become eligible, and if the program is on a contributory basis, I authorize my employer to deduct my share of the cost from my salary. **I further understand that I <u>must maintain this coverage for a minimum of twelve months</u> unless I am no longer employed with company.**

Signature of Enrolling Employee: ________________________________ ***Date:*** _____________

I understand and Agree that I must remain on the plan for at least 12 months unless I am dropped from the plan.

For Internal Use Only:
Effective Date: ________________
Date Entered: ________________
Keyed By: ____________________

Please direct any questions to the offices of *Infinity Trust*, available by phone at 1-800-788-8146.