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Vision Plan Employer Application

All applicable questions must be completed accurately and in detail to avoid delay. Please type or print all information. Additionally, we request that applications be submitted ten (10) days prior to the requested effective date to ensure the plan is implemented by the effective date.

Client Information

1. **Full legal name of group:** ______________________________

   Address: ______________________________

   City: ______________ **County:** ______________ **State:** _______ **Zip:** ____________

   Phone: ______________ **Fax:** ______________ **E-mail:** ______________

   Principal Contact ______________________________ **Title:** ______________

   Phone: ______________ **Fax:** ______________ **E-mail:** ______________

   Client is headquartered in state of ____________ **(if different from above)**

2. **Who should we contact with payment questions?**

   Name: ______________________________ **Title:** ______________

   Phone: ______________ **Fax:** ______________ **E-mail:** ______________

3. **Who should we contact with eligibility questions?**

   Name: ______________________________ **Title:** ______________

   Phone: ______________ **Fax:** ______________ **E-mail:** ______________

4. **Who is the Benefit Administrator responsible for the overall administration of the plan (if not principal contact)?**

   Name: ______________________________ **Title:** ______________

   Phone: ______________ **Fax:** ______________ **E-mail:** ______________

5. **What is the nature of your business?** ______________________________

   Standard Industry Code (SIC): ______________________ **Tax ID #** ______________

6. **Names of separate divisions that will be covered by this plan:** ______________________________

   ____

   Will a separate billing be needed for the above divisions? ______ **Yes** ______ **No**

   Billing address (if applicable): ______________________________

   Firm/Organization: ______________________________

   Address: ______________________________

   City: ______________ **County:** ______________ **State:** _______ **Zip:** ____________

   Phone: ______________ **Fax:** ______________ **E-mail:** ______________

7. **Send employee benefit information to: ____ Group's Benefit Administrator ____ TPA ____ Broker/Consultant**

8. **Prior VSP coverage: Yes _____ No _____**

   If yes, prior group name: ____

9. **Number of employees eligible for benefits: ____**

   Does this represent the total number of employees in the company? Yes _____ No _____ Total Number: ______

   Do you provide benefits to your retiree population? Yes _____ No _____

10. **Waiting period for employee:**

    ______ First of the month following Date of Hire

    ______ First day of month after 30 days

    ______ First day of month after 60 days

    ______ First day of month after 90 days

    ______ First day of month after ____

    Do you have a rehire agreement?

    Waiting period for rehires:

    ______ First of the month following Date of Hire

    ______ First day of month after 30 days

    ______ First day of month after 60 days

    ______ First day of month after 90 days

    ______ First day of month after ____

11. **Eligible Dependents are the following:**

    - ✓ **Legal spouse**
    - ✓ **Domestic partners (following state guidelines)**
    - ✓ **Dependent children up to age 26**
    - ✓ **Full-time college student up to age 30**
    - ✓ **Disabled dependents (under government guidelines)**

    ******* ***College students must submit a letter from the college they are attending as proof of full-time status.***

12. **Type of plan:**

    ______ Employer Contributory   **______ Employer's Percent of Contribution**

    ______ Voluntary Only   **______ Management Carve Out**

13. **REQUESTED EFFECTIVE DATE: ____**

Individuals enrolling in coverage, whether mandatory or voluntary, must maintain their participation in the plan for a minimum of 12 months from their effective day.

Plan Information

14. Design (please select one):

______ Signature Series ______ Choice Series WITH Lens Options ______ Choice Series WITHOUT Lens Options

15. Coverage (please select one):

______ Plan A ______ Plan B ______ Plan C ______ Exam Plus (Signature only)

16. Tier numbers and rate calculations:

Tier Levels	*Number of Employees*	*Rate*	*Total*
Employee			
Employee + 1			
Family			

SUBTOTAL: ______________________

17. Please choose how you would like to be billed. You will need to add the corresponding administration fee to the amount of premium you will be submitting. Premium payments must be submitted with all paperwork. *No case will be processed without initial premium payment*. If you have elected an EFT, it will begin with the second monthly invoice. An EFT form also needs to be completed.

______ Monthly Billing — **$10 Administration Fee each Month**

______ Monthly EFT Billing — **$10 Administration Fee each Draft**

______ Quarterly (3 Month) Billing — **$20 Administration Fee Quarterly**

______ Semi-Annual (6 Month) Billing — **$30 Administration Fee Semi-Annually**

SUBTOTAL: _________________ X __________ # MONTHS

ADMIN FEE AMOUNT: + **________________________**

TOTAL DUE: = **________________________**

PLEASE MAKE CHECK PAYABLE TO INFINITY TRUST

Agreement

The undersigned group hereby applies for vision care coverage through the Infinity Trust Vision Plan. It is understood that:

1. **Premium payments are due on or before the first day of the month in which premium is due;**
2. **Coverage for new enrollees will commence on the first day of the month following the waiting period;**
3. **Coverage will terminate on the last day of the month in which the employee's coverage is terminated;**
4. ***Employers agree to maintain coverage for a minimum of 12 months from effective date*;**
5. **Individuals enrolling in coverage, whether mandatory or voluntary, must maintain their participation in the plan for a minimum of 12 months from their effective date.**
6. **Employers understand that the Infinity Trust plans renew consistently on April 1st of even years. Rate increases will apply to your company no matter what month it became effective.**

This application is signed on the ______ day of ________________ in the year ______________________.

Firm/Organization: ____

Name: ____ Title: __________________________

Signature: ____

The Broker/Consultant indicated below is hereby designated Broker of Record by the above signed employer. (If not applicable, please disregard this page.)

[Please type or clearly print]

Legal Firm Name: ____

Address: ____

City: ____________________________ **County:** ___________________ **State:** ______ **Zip:** _____________

Licensed Producer's Name: ____________________________________ **Title:** _______________________

Phone: __________________________ **Fax:**______________________ **E-mail:** ______________________

Broker Assistant Name: ______________________________________ **E-mail:** _____________________

Taxpayer ID: ____ _____ **Corporation** _____ **Independent**

Commission Checks Payable to:

______ **Firm Name**

______ **Contact Name**

______ **Not Paid**

Name: ____

Address: ____

City: ____________________________ **County:** ___________________ **State:** ______ **Zip:** _____________

Send Administration Kit to: Broker/Consultant____________________**Employer/Contact**_____________________

This application is signed on the ______ day of ______________ in the year ___________________.

Firm/Organization: ____

Name: ____ **Title:** _______________________

Signature of state-licensed agent: ____

For Internal Use Only:
Effective Date:______________________________
Date Entered:_______________________________
Keyed By:__________________________________