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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 must maintain this coverage for a minimum of twelve months 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.