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

Individual Vision Coverage 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 date requested.

REQUESTED EFFECTIVE DATE: ____

Applicant Information

Last Name	First Name	MI	Gender ☐ M ☐ F
Home Address	**City**	**State**	**Zip**
Social Security #	**Date of Birth**	**Home Phone #**	

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

Plan Information

Coverage Option (please select one):

_____ Choice Series WITH Lens Options – Plan A
_____ Choice Series WITH Lens Options – Plan B
_____ Choice Series WITH Lens Options – Plan C

Tier level and rates ($40 Annual Administration Fee Included):

Tier Levels	*Plan A Rates*	*Plan B Rates*	*Plan C Rates*
Individual	**$164.08**	**$173.08**	**$209.44**
Individual + 1	**$218.32**	**$231.16**	**$282.76**
Family	**$364.12**	**$387.28**	**$395.44**

PLEASE MAKE CHECK PAYABLE TO INFINITY TRUST

Agreement

The applicant and all dependents listed are applying for vision care coverage through the Infinity Trust Vision Plan. It is understood that:

1. **Full annual premium is due at time of application.**
2. **Individuals enrolling in coverage must maintain their participation in the plan for a minimum of 12 months no refunds will be provided.**
3. **Policy is automatically renewed unless we receive 30 day written notification of termination.**
4. **Any rate increase will be billed at our annual renewal time April 1st every two years.**

This application is signed on the _____ day of _____ in the year _____.

Insured Name: _____

Insured Signature: _____

Broker / Consultant

The Broker/Consultant indicated below is hereby designated Broker of Record by the above signed individual. (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**
- **_____ Producer**
- **_____ Not Paid**

Name: _____

Address:_____

City: _____ County: _____ State: _____ Zip: _____

Send Administration Kit to:

Broker/Consultant: _____ Individual: _____

This application is signed on the _____ day of _____ in the year _____.

Signature of state-licensed agent: _____

INFINITY TRUST

VSP Vision care for life

Email **Print**

For Internal Use Only:
Effective Date:_____
Date Entered:_____
Keyed By:_____