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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: _____

Please Note: All forms may be filled out electronically. To begin, download the desired form to your local device and save. When complete, simply click EMAIL button to submit electronically.

Acrobat Reader is required. Click the logo to download the software. Further instructions may be found at: https://helpx.adobe.com/acrobat/using/filling-pdf-forms.html

Email Print

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