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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				
<b>Last Name</b>	<b>First Name</b>	<b>MI</b>	<b>Gender</b> <input type="checkbox"/> <b>M</b> <input type="checkbox"/> <b>F</b>	
<b>Home Address</b>		<b>City</b>	<b>State</b>	<b>Zip</b>
<b>Social Security #</b>		<b>Date of Birth</b>	<b>Home Phone #</b>	

### List Dependents

Relationship	First Name	Last Name	Date of Birth	Social Security #	Gender	Student
<b>Spouse</b>					<input type="checkbox"/> <b>M</b> <input type="checkbox"/> <b>F</b>	
<input type="checkbox"/> <b>Child</b> <input type="checkbox"/> <b>Adopted</b> <input type="checkbox"/> <b>Stepchild</b> <input type="checkbox"/> <b>Other</b>					<input type="checkbox"/> <b>M</b> <input type="checkbox"/> <b>F</b>	<input type="checkbox"/> <b>Y</b> <input type="checkbox"/> <b>N</b>
<input type="checkbox"/> <b>Child</b> <input type="checkbox"/> <b>Adopted</b> <input type="checkbox"/> <b>Stepchild</b> <input type="checkbox"/> <b>Other</b>					<input type="checkbox"/> <b>M</b> <input type="checkbox"/> <b>F</b>	<input type="checkbox"/> <b>Y</b> <input type="checkbox"/> <b>N</b>
<input type="checkbox"/> <b>Child</b> <input type="checkbox"/> <b>Adopted</b> <input type="checkbox"/> <b>Stepchild</b> <input type="checkbox"/> <b>Other</b>					<input type="checkbox"/> <b>M</b> <input type="checkbox"/> <b>F</b>	<input type="checkbox"/> <b>Y</b> <input type="checkbox"/> <b>N</b>
<input type="checkbox"/> <b>Child</b> <input type="checkbox"/> <b>Adopted</b> <input type="checkbox"/> <b>Stepchild</b> <input type="checkbox"/> <b>Other</b>					<input type="checkbox"/> <b>M</b> <input type="checkbox"/> <b>F</b>	<input type="checkbox"/> <b>Y</b> <input type="checkbox"/> <b>N</b>
<input type="checkbox"/> <b>Child</b> <input type="checkbox"/> <b>Adopted</b> <input type="checkbox"/> <b>Stepchild</b> <input type="checkbox"/> <b>Other</b>					<input type="checkbox"/> <b>M</b> <input type="checkbox"/> <b>F</b>	<input type="checkbox"/> <b>Y</b> <input type="checkbox"/> <b>N</b>

## 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):

<i>Tier Levels</i>	<i>Plan A Rates</i>	<i>Plan B Rates</i>	<i>Plan C Rates</i>
<b>Individual</b>	<b>\$164.08</b>	<b>\$173.08</b>	<b>\$209.44</b>
<b>Individual + 1</b>	<b>\$218.32</b>	<b>\$231.16</b>	<b>\$282.76</b>
<b>Family</b>	<b>\$364.12</b>	<b>\$387.28</b>	<b>\$395.44</b>

**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 1<sup>st</sup> 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>



For Internal Use Only:
Effective Date: \_\_\_\_\_
Date Entered: \_\_\_\_\_
Keyed By: \_\_\_\_\_