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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 ☐ Choice Elite (Choice w/LO) ☐ 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
Job Title	☐ Disabled ☐ Other: ________

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 <u>must maintain this coverage for a minimum of twelve months</u> unless I am no longer employed with company.**

Signature of Enrolling Employee: ________________________________ ***Date:*** ____________

Please direct any questions to the offices of *Infinity Trust*, available by phone at 1-800-788-8146.

For Internal Use Only:

Date Effective: ___________

Date Entered: ___________

Keyed By: ______________