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Vision Plan Employer 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 effective date.

Client Information

1. Full legal name of group: _____

Address: _____

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

Phone: _____ Fax: _____ E-mail: _____

Principal Contact _____ Title: _____

Phone: _____ Fax: _____ E-mail: _____

Client is headquartered in state of _____ (if different from above)

2. Who should we contact with payment questions?

Name: _____ Title: _____

Phone: _____ Fax: _____ E-mail: _____

3. Who should we contact with eligibility questions?

Name: _____ Title: _____

Phone: _____ Fax: _____ E-mail: _____

4. Who is the Benefit Administrator responsible for the overall administration of the plan (if not principal contact)?

Name: _____ Title: _____

Phone: _____ Fax: _____ E-mail: _____

5. What is the nature of your business? _____

Standard Industry Code (SIC): _____ Tax ID # _____

6. Names of separate divisions that will be covered by this plan: _____

Will a separate billing be needed for the above divisions? _____ Yes _____ No

Billing address (if applicable): _____

Firm/Organization: _____

Address: _____

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

Phone: _____ Fax: _____ E-mail: _____

7. Send employee benefit information to: Group's Benefit Administrator TPA Broker/Consultant

8. Prior VSP coverage: Yes No

If yes, prior group name: _____

9. Number of employees eligible for benefits: _____

Does this represent the total number of employees in the company? Yes No Total Number: _____

Do you provide benefits to your retiree population? Yes No

10. Waiting period for employee:

First of the month following Date of Hire

First day of month after 30 days

First day of month after 60 days

First day of month after 90 days

First day of month after _____

Do you have a rehire agreement?

Waiting period for rehires:

First of the month following Date of Hire

First day of month after 30 days

First day of month after 60 days

First day of month after 90 days

First day of month after _____

11. Eligible Dependents are the following:

- Legal spouse
- Domestic partners (following state guidelines)
- Dependent children up to age 26
- Disabled dependents (under government guidelines)

12. Type of plan:

Employer Contributory

Employer's Percent of Contribution

Voluntary Only

Management Carve Out

13. REQUESTED EFFECTIVE DATE: _____

Individuals enrolling in coverage, whether mandatory or voluntary, must maintain their participation in the plan for a minimum of 12 months from their effective day.

Plan Information

14. Design (please select one):

_____ Signature Series _____ Choice Series WITH Lens Options

Coverage (please select one):

Plan A: _____ Plan B: _____ Plan C: _____ Choice Elite (Choice Series Only): _____ Exam Plus (Signature Series Only): _____

15. Tier numbers and rate calculations:

Tier Levels	Number of Employees	Rate	Total
Employee			
Employee + 1			
Family			

SUBTOTAL: _____

16. Please choose how you would like to be billed. You will need to add the corresponding administration fee to the amount of premium you will be submitting. Premium payments must be submitted with all paperwork. ***No case will be processed without initial premium payment.*** If you have elected an EFT, it will begin with the second monthly invoice. An EFT form also needs to be completed.

_____ Monthly Billing

_____ Monthly EFT Billing

_____ Quarterly (3 Month) Billing

\$20 Administration Fee Quarterly

_____ Semi-Annual (6 Month) Billing

\$30 Administration Fee Semi-Annually

SUBTOTAL: _____ X _____ # MONTHS

+

ADMIN FEE AMOUNT: _____

TOTAL DUE: _____

**PLEASE MAKE CHECK PAYABLE
TO ISI INFINITY GROUP**

Agreement

The undersigned group hereby applies for vision care coverage through the ISI Infinity Group Vision Plan. It is understood that:

1. Premium payments are due on or before the first day of the month in which premium is due;
2. Coverage for new enrollees will commence on the first day of the month following the waiting period;
3. Coverage will terminate on the last day of the month in which the employee's coverage is terminated;
4. ***Employers agree to maintain coverage for a minimum of 12 months from effective date;***
5. Individuals enrolling in coverage, whether mandatory or voluntary, must maintain their participation in the plan for a minimum of 12 months from their effective date.

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

Firm/Organization: _____

Name: _____ Title: _____

Signature: _____

Broker / Consultant

The Broker/Consultant indicated below is hereby designated Broker of Record by the above signed employer. (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

Contact Name

Not Paid

Name: _____

Address: _____

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

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

Firm/Organization: _____

Name: _____ Title: _____

Signature of state-licensed agent: _____

