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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**
Email Address			
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

Plan Information

Coverage Option (please select one):

- ☐ **Choice – Plan A**
- ☐ **Choice – Plan B**
- ☐ **Choice – Plan C**
- ☐ **Choice Elite Plan**

Tier level and rates ($20 Annual Administration Fee Included):

Tier Levels	*Plan A Rates*	*Plan B Rates*	*Plan C Rates*	*Elite Rates*
Individual	**$160.64**	**$170.96**	**$212.12**	**$230.96**
Individual + 1	**$222.20**	**$236.84**	**$295.28**	**$322.28**
Family	**$387.56**	**$413.84**	**$423.08**	**$462.56**

PLEASE MAKE CHECK PAYABLE TO

ISI INFINITY GROUP

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: _____

For Internal Use Only:
Effective Date: _____

Date Entered: _____

Keyed By: _____