Email: itenrollment@insurancestrategyinc.com
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6368 Pearl Road
Main Floor
Cleveland, OH 44130

Phone: 440-842-9922
800-788-8146
Fax: 440-842-8669

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

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	☐ 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 ☐ Disabled ☐ Other: _________	
Job Title			

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

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

I understand and Agree that I must remain on the plan for at least 12 months unless I am dropped from the plan.

For Internal Use Only:
Effective Date: ________________
Date Entered: __________________
Keyed By: _____________________

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