VACE*Plus*

VSP 2018

Employee Benefits

PO Box 810 Montpelier VT 05601 229-2231

Offered exclusively to members of participating Chambers of Commerce

Employer Enrollment Agreement

Business Name/Employer Name: _____

Employer Contact Name: _____

Billing Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Contact Phone #: (___) _____ Contact E-Mail Address: _____

Town in which Business is Physically Located: _____

Proposed Effective Date of Coverage: _____

I hereby certify by my signature that my firm is a member in good standing with the _____ Chamber of Commerce. I understand that my firm's ability to obtain and maintain this coverage is predicated on my firm's maintaining its membership with the Chamber.

Insurance Agency: _____

Insurance Agent Name: _____

Authorized signature of Employer: _____

Title: _____ **Date: _____**

Vision Service Plan (VSP)

Employee: _____$12.00

Employee + Spouse or child: _____$19.00

Employee + Family: _____$29.00