VACE*plus* INSURANCE PROGRAM
VISION SERVICE PLAN
MEMBERSHIP TERMINATION FORM

Name of Employer/VACE ID#________________________________ Coverage Termination Date ___________

1	Social Security No.	Last Name/First Name/ MI	M F	Date of Birth
	___________________	____________________________________	_______	_________________

2	Reasons for Termination (Qualifying Event)			
		Termination of Employment		Divorce/Termination of a civil Union
		Reduction of hours		Deceased
		Other coverage		Retirement
		Annual Open Enrollment		Other

SIGNATURE ____ **Date**__________________

Please return form to:

VACE Insurance Program
PO Box 810
Montpelier VT 05601
FAX: 802-223-4257
EMAIL: vacehealth@vtchamber.com