

Vision Service Plan
 Membership Enrollment Form
 VACE^{plus} Insurance

Please return form to:
 VACE^{plus} Insurance Program
 PO Box 810, Montpelier, VT 05601
 Fax: 802-223-4257
 Email: vacehealth@vtchamber.com



Name of Group/Employer _____ VACE ID# _____ Coverage Effective Date _____

1	Social Security No.	Last Name/First Name/ MI	M / F	Date of Birth
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Coverage Level and Rates									
2	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%;">Choose a level</td> <td style="text-align: right;">Monthly Rates</td> </tr> <tr> <td>Employee Only</td> <td style="text-align: right;">\$12.00</td> </tr> <tr> <td>Employee + 1 (Spouse/ Domestic Partner/ Civil Union or child)</td> <td style="text-align: right;">\$19.00</td> </tr> <tr> <td>Employee + 2 or more (spouse/ Domestic Partner/ Civil Union/children)</td> <td style="text-align: right;">\$29.00</td> </tr> </table>	Choose a level	Monthly Rates	Employee Only	\$12.00	Employee + 1 (Spouse/ Domestic Partner/ Civil Union or child)	\$19.00	Employee + 2 or more (spouse/ Domestic Partner/ Civil Union/children)	\$29.00
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Qualifying Event (Reason for Enrollment)										
3	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 40%;">New employment – date of hire/re-hire _____</td> <td style="width: 10%;"></td> <td style="width: 45%;">Employment status change</td> </tr> <tr> <td>Open enrollment</td> <td></td> <td>Employee Marital status change</td> </tr> <tr> <td>Loss of other Coverage</td> <td>Other – Please explain</td> <td></td> </tr> </table>	New employment – date of hire/re-hire _____		Employment status change	Open enrollment		Employee Marital status change	Loss of other Coverage	Other – Please explain	
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Loss of other Coverage	Other – Please explain									

Please list all of your dependents that will be enrolled (Put extra names on a separate sheet of paper and put name of company on top of page)				
4	Last Name/First Name/ MI	M / F	Relationship	Date of Birth

Employee Signature _____ Date _____ Expires 12/31/2020

I certify that all information is true and correct to the best of my knowledge. I understand that my dependents and I must remain enrolled and can discontinue our coverage only during open enrollment, except in the event of a qualified change.