

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