VACEplus 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