VACE*Plus* INSURANCE PROGRAM
VISION SERVICE PLAN
MEMBERSHIP ENROLLMENT FORM

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

1	Social Security No.	Last Name/First Name/ MI	M F	Date of Birth
	_____	_____	_____	_____

2	**Coverage Level and Rates**		
	Choose One		Monthly Rates
		Employee Only	$12.00
		Employee + 1	$19.00
		Employee + 2 or more	$29.00

PLEASE LIST ALL OF YOUR DEPENDENTS THAT WILL BE ENROLLED IN THE PROGRAM

3	Last Name/First Name/ MI	M F	Date of Birth
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

SIGNATURE _____ **Date**_____

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