VACE / CIGNA PLAN ENROLLMENT & CHANGE FORM

Please return completed enrollment forms to

VACE INSURANCE PROGRAM **(Provided by Chamber Benefits Inc.)**
P.O. BOX 810
MONTPELIER, VT 05601

Phone: 802-229-2231 Fax: 802-223-4257
E-mail: vacehealth@vtchamber.com

Social Security No: - -

Employer Name:

Name: (First, MI, Last)

Employee Email (for CIGNA / VACE use only)

Home Address:

City, State, Zip:

Date of Birth :

Marital Status: (please check one only)

( ) Single ( ) Legally Separated
( ) Married ( ) Widowed
( ) Divorced ( ) Civil Union
( ) Domestic Partner

Select CIGNA Insurance Type, if coverage desired:
(please check one only - verify with your employer options available to you)

( ) 600 OAP ( ) 2,500 OAP ( ) 2,250 HSA OAP
( ) 1000 OAP ( ) 3,000 OAP ( ) 3,500 HSA OAP

Health Plan Coverage Desired: (please check one only)

( ) Single (employee only)
( ) Two Person (employee + 1 dependent)
( ) Family (employee + 2 or more dependents)
( ) Medicare Supplement (employee only)
( ) I Refuse Coverage (please refer to signature box)

COMPLETE THE FOLLOWING SECTION FOR ALL PERSONS COVERED - If full time student and age 19 or over, attach proof verifying student status. If totally disabled prior to age 19, attach proof of disability for eligibility review**.**

Relationship	Add	Delete	Name (Include last name, if different)	Sex M	Sex F	Social Security No.	Date of Birth mo/day/yr	√ If Resides with Employee	√ If Step-Child	√ If Full Time Student 19-25?
Self										
Spouse										
Civil Union Partner										
Domestic Partner										
Child										
Child										
Child			add additional on separate paper							

OTHER HEALTH CARE COVERAGE:
Do you or your dependents have other health insurance under a group plan, HMO, or Medicare that is not being replaced by this plan? ( ) No ( ) Yes If YES, please provide the following:
NAME OF PERSON COVERED SOC. SEC. NO. EMPLOYER INSURANCE CO. NAME

Employer Completes This Section

VACE ID # _____ CIGNA GROUP # 3212892

EMPLOYER PROBATION PERIOD: _____DAYS NEW HIRES
_____DAYS REHIRES

ADDITION

( ) New Hire
( ) Rehire
( ) Open Enrollment
( ) Cobra / Viper
( ) Full-time Status

CANCELLATION

( ) Left Employment
( ) Other Insurance
( ) Voluntary
( ) Cobra / Viper Ending

CHANGES - check boxes that apply

( ) Address Change ( ) Name Change

( ) Convert to VACE / CIGNA Medicare Supplement

ADD DEPENDENT

( ) Birth
( ) Marriage/Civil Union/Domestic Part.
( ) Adoption
( ) Other (explain on line below)

DELETE DEPENDENT

( ) Divorce
( ) Legal Separation
( ) Change in Student Status
( ) Other (explain on line below)

DATE OF HIRE / REHIRE	DATE OF EVENT	**EFFECTIVE DATE**

Signature Box

I hereby request enrollment of myself and eligible family dependents and authorize my employer to deduct from my wages or salary the amount of contributions, if any, for the coverage requested. I understand that the coverage provided will be subject to the terms and conditions of the group insurance policy. I authorize any licensed physicians, hospital, clinic, pharmacist, employer, and all other agencies or organizations to permit CIGNA HealthCare to see, or to get a copy of, all medical records, prescribed drug, employment and insurance coverage records which pertain to me or my enrolled dependents. The information above is true and correct to the best of my knowledge and I understand that my benefits may be affected by failure to provide complete, accurate and timely information.

( ) I accept medical coverage.
( ) I decline medical coverage and understand I must wait for the next open enrollment period if I desire coverage in the future.

Employee please sign here **Date**