

**VACE/CIGNA HealthCare  
ENROLLMENT AGREEMENT**

Group Name: \_\_\_\_\_

Group Contact Person: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax#: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Town in Which Business is Physically Located: \_\_\_\_\_

Proposed Effective Date of Coverage: \_\_\_\_\_

Total Number of Eligible Full-Time Employees: \_\_\_\_\_

Hours Needed to be considered eligible for health insurance: \_\_\_\_\_

Primary Business Activity: \_\_\_\_\_

Please select the OAP Deductible Plan(s) that you wish to offer your employees:

OAP Plan Deductible: Employers can choose up to two plans.

600 \_\_\_\_\_ 2,500 \_\_\_\_\_ 2,250 HSA \_\_\_\_\_

1000 \_\_\_\_\_ 3,000 \_\_\_\_\_ 3,500 HSA \_\_\_\_\_

Group Probationary Period : Period employees must wait after they are hired/rehired to come on insurance.

New Employees : \_\_\_\_\_ Rehires: \_\_\_\_\_

Binder check for the first months coverage in the amount of \$ \_\_\_\_\_ is attached.

I hereby certify by my signature that my firm is a member in good standing with The \_\_\_\_\_  
\_\_\_\_\_ Chamber of Commerce. I understand that my firm's ability to obtain and maintain this coverage is predicated on my firm's maintaining its membership with this Chamber.

Insurance Agency: \_\_\_\_\_

Insurance Agent Name: \_\_\_\_\_

Authorized Signature of Employer: \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_\_\_