

**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 _____ 2,450 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: _____