

**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 Employees (full and part-time) _____
Total Number of Eligible 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.

1,250 _____ 2,500 _____ 3,000 _____ 4,000 _____

2,450 HSA _____ 3,500 HSA _____ 5,000 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: _____