

**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.

1,500 _____ 2,000 _____ 2,500 _____ 3,000 _____

4,000 _____ 2,450 HSA _____ 5,950 HSA _____

Does your group plan to contribute to an employee Health Savings Account (HSA)? Yes or No

Does your group plan to contribute to an employee Health Reimbursement Account (HRA)? Yes or No

If so, please check a range of your contribution: 0-50% of deductible 51-100% of deductible

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: _____