

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: <small>(First, MI, Last)</small>	Employee Email (for CIGNA / VACE use only)
Home Address:	Select CIGNA Insurance Type, if coverage desired: <small>(please check one only - verify with your employer options available to you)</small> <input type="checkbox"/> 600 OAP <input type="checkbox"/> 2,500 OAP <input type="checkbox"/> 2,250 HSA OAP <input type="checkbox"/> 1000 OAP <input type="checkbox"/> 3,000 OAP <input type="checkbox"/> 3,500 HSA OAP
City, State, Zip:	Health Plan Coverage Desired: <small>(please check one only)</small> <input type="checkbox"/> Single <small>(employee only)</small> <input type="checkbox"/> Two Person <small>(employee + 1 dependent)</small> <input type="checkbox"/> Family <small>(employee + 2 or more dependents)</small> <input type="checkbox"/> Medicare Supplement <small>(employee only)</small> <input type="checkbox"/> I Refuse Coverage <small>(please refer to signature box)</small>
Date of Birth :	
Marital Status: <small>(please check one only)</small> <input type="checkbox"/> Single <input type="checkbox"/> Legally Separated <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Civil Union <input type="checkbox"/> Domestic Partner	

Employer Completes This Section

VACE ID # _____ CIGNA GROUP # 3212892

EMPLOYER PROBATION PERIOD: _____ DAYS NEW HIRES
 _____ DAYS REHIRES

<u>ADDITION</u>	<u>CANCELLATION</u>
<input type="checkbox"/> New Hire	<input type="checkbox"/> Left Employment
<input type="checkbox"/> Rehire	<input type="checkbox"/> Other Insurance
<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Voluntary
<input type="checkbox"/> Cobra / Viper	<input type="checkbox"/> Cobra / Viper Ending
<input type="checkbox"/> Full-time Status	

CHANGES - check boxes that apply

Address Change Name Change

Convert to VACE / CIGNA Medicare Supplement

<u>ADD DEPENDENT</u>	<u>DELETE DEPENDENT</u>
<input type="checkbox"/> Birth	<input type="checkbox"/> Divorce
<input type="checkbox"/> Marriage/Civil Union/Domestic Part.	<input type="checkbox"/> Legal Separation
<input type="checkbox"/> Adoption	<input type="checkbox"/> Change in Student Status
<input type="checkbox"/> Other (explain on line below)	<input type="checkbox"/> Other (explain on line below)

DATE OF HIRE / REHIRE	DATE OF EVENT	EFFECTIVE DATE
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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	A d d	D e l e t e	Name (Include last name, if different)	Sex		Social Security No.	Date of Birth mo/day/yr	✓ If Resides with Employee	✓ If Step-Child	✓ If Full Time Student 19-25?
				M	F					
Self										
Spouse										
Civil Union Partner										
Domestic Partner										
Child										
Child										
Child			add additional on separate paper							

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**

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