ACCE EMPLOYEE ENROLLMENT/CHANGE FORM

EMPLOYEE BENEFIT INSURANCE PLANS

☐ New Enrollee ☐ Name Change ☐ Address Change ☐ Beneficiary Change ☐ Plan Change ☐ Marriage

☐ Add Dependents ☐ Change from Part-time to Full-time ☐ Divorce ☐ Lost Coverage ☐ Salary Change

☐ Transfer from Chamber ID# _____ ☐ Waive Waiting Period *(To waive the waiting period, please attach authorization)*

1. EMPLOYER INFORMATION

Employer Name _____ Chamber ID# _____

2. EMPLOYEE INFORMATION Please write legibly

Last Name _____ First Name _____ MI _____

Street Address _____ City, State _____ Zip_____

Employee Email _____ Employee Title _____

Job Function (circle one): Workforce/Education Bus. Development Community Development Finance Global Trade Admin Tourism Sales Membership Economic Development Events Government Relations Communications HR Marketing

Social Security # _____ Date of Birth _____ Date of Hire _____

Do you work 30+ hours per week? ☐ Yes ☐ No Are you married? ☐ Yes ☐ No

Annual Salary _____ Gender: ☐ Male ☐ Female

3. COVERAGE/BENEFITS REQUESTED Please complete side 2 of this form to add dependent coverage

☐ **Term Life and AD&D** ☐ Employee

☐ **Dependent Life** ☐ Family

☐ **Long-Term Disability** ☐ Employee

☐ **Short-Term Disability** ☐ Employee

☐ **Dental PPO** ☐ Employee ☐ Spouse ☐ Children

☐ **Vision Plan** ☐ Employee ☐ Spouse ☐ Children

☐ **Voluntary Accident w/ Travel Benefits:** ☐ **Employee** ☐ **Family**

☐ $10,000 ☐ $20,000 ☐ $50,000 ☐ $100,000 ☐ $250,000 ☐ $300,000 ☐ $500,000

4. SIGNATURE This form cannot be processed without both signatures

I hereby apply for the insurance for which I am now or may become eligible under provisions of the group policy issued to the policyholder by UNUM Life, VSP, and CIGNA HeathCare Dental. I authorize the addition or change of my beneficiaries and/or dependents. To the best of my knowledge and belief, the information I have provided on this form is complete and correct. I authorize payment of Life and Dental to preferred providers, where applicable, for those charges covered by my group benefits. I authorize release to or by UNUM of any medical information including copies of medical records or insurance information as necessary for claims adjudication, utilization review, or coordination of benefits. These authorizations shall remain valid during my term of coverage under my group insurance plan. My authorized representative or I may request a copy of the authorization, whereas a photocopy shall be considered valid.

Employee Signature _____ Date _____

Employer Signature _____ Date _____

Over please.

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5. DEPENDENT INFORMATION Attach additional as necessary

FULL NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATION TO EMPLOYEE	FULL TIME STUDENT *(YES/NO)*	OTHER COVERAGE *(YES/NO)*

6. BENEFICIARY INFORMATION

PRIMARY BENEFICIARY			
FULL NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP

CONTINGENT BENEFICIARIES			
FULL NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP

7. SIGNATURE

I authorize the addition or change of my beneficiaries and/or dependents.

Employee Signature _____ Date _____

RETURN TO ACCE BENEFITS SERVICES

Scan and email to: snorris@acce.org | 1330 Braddock Pl, Suite 300, Alexandria, VA 22314 | Phone: 800-394-2223