

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

PLEASE PRINT CLEARLY

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"/> 1,500 OAP <input type="checkbox"/> 2,500 OAP <input type="checkbox"/> 3,000 OAP <input type="checkbox"/> 4,000 OAP <input type="checkbox"/> 2,000 HSA OAP <input type="checkbox"/> 2,450 HSA OAP <input type="checkbox"/> 5,950 HSA OAP
City, State, Zip:	
Date of Birth :	Health Plan Coverage Desired: (please check one only)
Marital Status: (please check one only)	<input type="checkbox"/> Single (employee only) <input type="checkbox"/> Two Person (employee + 1 dependent) <input type="checkbox"/> Family (employee + 2 or more dependents) <input type="checkbox"/> Medicare Supplement (employee only) <input type="checkbox"/> I Refuse Coverage (please refer to signature box)
<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	<input type="checkbox"/> Other (explain below)
<input type="checkbox"/> Other (explain below)	

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 <u>DATE</u>
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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**

See Special Enrollment Notice on Reverse

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

Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within "30 days" after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within "30 days" after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact VACE Insurance at 802-229-2231 or VACEHealth@VTChamber.com