Vision Service Plan
Membership Enrollment Form
VACE*plus* Insurance

Please return form to:
VACE*plus* Insurance Program
PO Box 810, Montpelier, VT 05601
Fax: 802-223-4257
Email: vacehealth@vtchamber.com

VSP Vision care for life

Name of Group/Employer _____ VACE ID# _____ Coverage Effective Date _____

1	Social Security No.	Last Name/First Name/ MI	Gender	Date of Birth

2	Coverage Level and Rates	
	Choose a level	**Monthly Rates**
	Employee Only	$16.00
	Employee + 1 (Spouse/ Domestic Partner/ Civil Union or child)	$24.00
	Employee + 2 or more (spouse/ Domestic Partner/ Civil Union/children)	$36.00

3	Qualifying Event (Reason for Enrollment)			
		New employment – date of hire/re-hire _____		Employment status change
		Open enrollment		Employee Marital status change
		Loss of other Coverage		Other – Please explain

4	Please list all of your dependents that will be enrolled (Put extra names on a separate sheet of paper and put name of company on top of page)			
	Last Name/First Name/ MI	**Gender**	**Relationship**	**Date of Birth**

Employee Signature _____ Date _____

Expires 12/31/2023

I certify that all information is true and correct to the best of my knowledge. I understand that my dependents and I must remain enrolled and can discontinue our coverage only during open enrollment, except in the event of a qualified change.