ACCE ORGANIZATION ENROLLMENT FORM

EMPLOYEE BENEFIT INSURANCE PLANS

1 FILL OUT THE FORM to indicate the plans to be offered to your employees

2 HAVE EACH ELIGIBLE EMPLOYEE complete the ACCE Employee Enrollment/Change Form

3 MAIL THIS FORM & EACH EMPLOYEE ENROLLMENT FORM TO: ACCE Benefits Services, 1330 Braddock Place, Suite 300, Alexandria, VA 22314 Call: 1-800-394-2223 or snorris@acce.org

☐ New Plan Enrollment ☐ Plan Change

1. EMPLOYER INFORMATION Please write legibly

Contact Name ______________________ 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

Organization ______________________

Street Address ______________________ City, State Zip ______________________

Phone # ( )______________ Fax # ( )______________ Email ______________

Number of Employees working more than 30 hours per week______________

2. PLEASE CHOOSE PLAN WAITING PERIOD Applicable to Term Life, AD&D, Disability and Vision Plans.

Waiting Period Options - coverage effective 1st day of the month following: ☐ Hire date ☐ 30 days ☐ 60 days ☐ 90 days

3. PLEASE CHOOSE PLAN(S) & BENEFIT OPTIONS

Proof of Insurability forms will be supplied if applicable. They must be completed and reviewed by the insurance carrier before your application can be processed.

☐ **Term Life and AD&D** Benefit Options: ☐ 2.5x Salary ☐ 2x Salary ☐ 1.5x Salary

☐ **Long-Term Disability** Elimination Period Options: ☐ 90-Day Elimination Period ☐ 180-Day Elimination Period

☐ **Short-Term Disability** Benefit Duration Options: ☐ Option 1: 9 Weeks ☐ Option 2: 22 Weeks ☐ Option 3: 12 Weeks

☐ **Dental PPO**

☐ **Vision**

☐ **Voluntary Accident Insurance w/ Travel Benefits**

If this is a change to your current ACCE Plan, what is your Chamber ID Number? ______________________

If coverage is being transferred from another carrier, please provide name: ______________________

If requesting coverage for the first time, state the effective date: ______________________

4. SIGNATURE

I have read the ACCE Group Insurance materials and hereby agree to be bound by the terms, conditions and provisions of the policies issued by the carrier and to assume the obligations of a participating member.

Signature ______________________ Date ______________