ACCE EMPLOYEE INSURANCE ENROLLMENT FORM

EMPLOYEE BENEFIT INSURANCE PLANS

☐ New Enrollee ☐ Part-time to Full-time Change

-OR- Select a Qualifying Event From the Below Options and Provide Date of the Qualifying Event: _____

☐ Plan Change ☐ Marriage ☐ Add Dependents ☐ Divorce ☐ Lost Coverage ☐ Transfer from _____

☐ Waive Waiting Period *(To waive the waiting period, please attach authorization)*

1. EMPLOYER INFORMATION

Employer Name _____

2. EMPLOYEE INFORMATION Please write legibly

Last Name _____ First Name _____ MI _____

Home Address _____ City, State _____ Zip _____

Work 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 _____

Number of hours worked **per week** _____ Are you married? ☐ Yes ☐ No

Salary (**Annual**) _____ Gender: ☐ Male ☐ Female

3. COVERAGE/BENEFITS REQUESTED Please complete #4 and #5 on this form to add dependent coverage and/or beneficiary election

☐ **Term Life and AD&D**

☐ **Dependent Life**

☐ **Long-Term Disability**

☐ **Short-Term Disability**

☐ **Dental PPO** Coverage Type: ☐ Employee ☐ Employee +Spouse ☐ Employee +Child(ren) ☐ Full Family

☐ **Vision Plan** Coverage Type: ☐ Employee ☐ Employee +1 ☐ Full Family

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

Benefit Options: ☐ $10,000 ☐ $20,000 ☐ $50,000 ☐ $100,000 ☐ $250,000 ☐ $300,000 ☐ $500,000

4. DEPENDENT COVERAGE

Please include spouse and all dependents who are eligible for life, dental, vision, or voluntary accident coverage on additional list if necessary

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

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5. BENEFICIARY INFORMATION

PRIMARY BENEFICIARY				
FULL NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATION TO EMPLOYEE	PECENTAGE (Must total 100%)

CONTINGENT BENEFICIARY				
FULL NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATION TO EMPLOYEE	PECENTAGE (Must total 100%)

6. 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/Title _____ Date _____

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Scan and email to: accebenefitsteam@acce.org