VOLUNTARY ACCIDENT INSURANCE ENROLLMENT FORM

ACCE VOLUNTARY ACCIDENT INSURANCE

1 COMPLETE THE FORM AND RETURN TO EMPLOYER FOR SIGNATURE

2 EMPLOYER MUST RETURN TO ACCE BENEFITS SERVICES: 1330 Braddock Place, Suite 300, Alexandria, VA 22314

3 QUESTIONS? CONTACT ACCE BENEFITS SERVICES: 800-394-2223 snorris@acce.org

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 ______________

3. COVERAGE/BENEFITS REQUESTED ☐ Employee ☐ Employee + Family

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

Benefit Coverage	$10,000	$20,000	$50,000	$100,000	$250,000	$300,000	$500,000
Individual Monthly Premium	$.26	$.52	$1.30	$2.50	$6.50	$7.80	$13.00
Individual + Family Monthly Premium	$.39	$.78	$1.95	$3.90	$9.75	$11.70	$19.50

4. DEPENDENT INFORMATION Attach additional pages as necessary

FULL NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP

5. BENEFICIARY INFORMATION Attach additional pages as necessary

FULL NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP

6. EMPLOYEE SIGNATURE

I hereby apply for the Voluntary Accident insurance under provisions of the policy issued to the policyholder by Cigna. I agree that selected coverage premiums will be paid via payroll deduct through my employer.

Signature ______________________________________ Date ______________

7. EMPLOYER SIGNATURE

I acknowledge and agree that the above employee's selected coverage premiums will be paid by them via payroll deduct.

Signature ______________________________________ Date ______________