

# ACCE EMPLOYEE ENROLLMENT/CHANGE FORM

## EMPLOYEE BENEFIT INSURANCE PLANS

New Enrollee  Name Change  Address Change  Beneficiary Change  Part-time to Full-time Change  Salary 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 Chamber ID# \_\_\_\_\_

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

### 1. EMPLOYER INFORMATION

Employer Name \_\_\_\_\_ Chamber ID# \_\_\_\_\_

### 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

Annual Salary \_\_\_\_\_ Gender:  Male  Female

### 3. COVERAGE/BENEFITS REQUESTED Please complete side 2 of this form to add dependent coverage

**Term Life and AD&D**  Employee

**Dependent Life**  Family

**Long-Term Disability**  Employee

**Short-Term Disability**  Employee

**Dental PPO**  Employee  Spouse  Children

**Vision Plan**  Employee  Spouse  Children

**Voluntary Accident w/ Travel Benefits:**  Employee  Family

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

### 4. 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 HealthCare 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 \_\_\_\_\_

Over please.

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### 5. DEPENDENT INFORMATION Include spouse and all dependents who are eligible for 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)

### 6. BENEFICIARY INFORMATION

PRIMARY BENEFICIARY			
FULL NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP

CONTINGENT BENEFICIARIES			
FULL NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP

### 7. SIGNATURE

I authorize the addition or change of my beneficiaries and/or dependents.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

### RETURN TO ACCE BENEFITS SERVICES

Scan and email to: [snorris@acce.org](mailto:snorris@acce.org) | 1330 Braddock Pl, Suite 300, Alexandria, VA 22314 | Phone: 800-394-2223

