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	$2.60	$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 _____