VACE*Plus*

VSP 2022

Employee Benefits

PO Box 810 Montpelier VT 05601 229-2231

Offered exclusively to members of participating Chambers of Commerce

Employer Enrollment Agreement for VSP

Business/Company Name: _____

Employer Contact Name: _____

Billing Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Contact Phone #: (___) _____ Contact E-Mail Address: _____

Town in which Business is Physically Located: _____

Proposed Effective Date of Coverage: _____

I Hereby certify by my signature that my firm is a member in good standing with the _____ Chamber of Commerce. I understand that my firm's ability to obtain and maintain this coverage is predicated on my firm's maintaining its membership with the Chamber.

Insurance Agency: _____

Insurance Agent Name: _____

Monthly invoices: Mailed - Yes or No, Emailed – Yes or No. If emailed, please indicate email address:

Invoices can be mailed and emailed.

Authorized signature of Employer: _____

Title: _____ **Date: _____**

Please return all forms to VACE Insurance, PO Box 810, Montpelier VT 05601 or vacehealth@vtchamber.com

Vision
Employee: _____$14.00
Two Person: _____$22.00
1 Adult Family: _____$34.00