

# VACEPlus

2023

## Employee Benefits

PO Box 810 Montpelier VT 05601 229-2231

Offered exclusively to members of participating Chambers of Commerce

## Employer Enrollment Agreement

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 (If Applicable): \_\_\_\_\_

Insurance Agent Name (If Applicable): \_\_\_\_\_

Monthly invoices: Mailed or Emailed or both \_\_\_\_\_

If emailed, please indicate email address: \_\_\_\_\_

Authorized signature of Employer: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Please return all forms to VACE Insurance, PO Box 810, Montpelier VT 05601 or [vacehealth@vtchamber.com](mailto:vacehealth@vtchamber.com)

	Vision
Employee: _____	\$16.00
Two Person: _____	\$24.00
1 Adult Family: _____	\$36.00