VISION CONTINUATION FORM

NOTIFICATION OF RIGHT TO CONTINUE VISION BENEFITS

THIS FORM MUST BE RETURNED TO ACCE BENEFITS SERVICES WITHIN 60 DAYS OF TERMINATION DATE

☐ Employee Termination Date: ________________ Employee terminations are always effective on the last day of the month

1. EMPLOYER INFORMATION

Employer Name ____

2. EMPLOYEE INFORMATION Please write legibly

Last Name ____ First Name _________________________________ MI _________

Home Address ____ City, State _________________________________ Zip__________

Work Email ____ Employee Title ____

Social Security # ____

3. COVERAGE/BENEFITS AFFECTED

Policy Holder Name: ACCE Policy Trust Policy Number: 12180779

I have been informed of my option to continue the vision benefits for myself and/or my dependents, if any, for 18 months and I have chosen to:

☐ Elect to continue with my employer's vision benefits by paying the premium required and providing my employer with the information necessary to continue my coverage.

☐ Elect not to continue with my employer's vision benefits.

I understand that coverage will cease when I, my spouse and/or my dependent become(s) enrolled in another plan or when the vision plan sponsored through my former employer terminates. I understand failure to remit payment to my former employer by the due date or within 30 days of the due date will result in cancellation of coverage with no reinstatement allowed. I understand that in order to continue these vision benefits, the payment which I must remit monthly to my former employer is determined as follows:

Employee - $13.44 Employee + One - $18.90 Full Family - $33.87

Rates are subject to change as a result of plan revisions.

4. SIGNATURES This form cannot be processed without both signatures

Employee Signature ____ Date __________________

Employer Signature/Title ____ Date __________________

RETURN TO ACCE BENEFITS SERVICES WITHIN 60 DAYS OF TERMINATION DATE

Scan and email to: accebenefitsteam@acce.org