VACE *plus*

VACEplus Insurance Program
P.O. Box 810
Montpelier, VT 05601

DELTA DENTAL®

Application To Join The VACEplus Insurance Program Delta Dental Plan

Acceptance of this Application makes the Employer a Participating Employer subject to the terms and conditions of the Group Contract between the VACEplus Insurance Program and Delta Dental Plan of Vermont.

Fax: _____

EMPLOYER: _____ TELEPHONE: (802) _____

ADDRESS: _____ CITY: _____ VT ZIP: _____

TOWN IN WHICH BUSINESS IS PHYSICALLY LOCATED _____

GROUP CONTACT: _____ EMAIL: _____

Prior Dental Coverage: _____ (Attach copy of prior Dental Plan Benefit Booklet and prior month's invoice)

Eligibility (Probationary) Period: First day of the month following _____ months.

DENTAL PROGRAM:	Plan 1 - PPO plus Premier Copayment	Plan 2 - PPO Copayment	Plan 3 - PPO plus Premier Copayment
Coverage A	100%*	100%*	100%*
Coverage B (after 6 month waiting period)	80%*	60%*	50%*
Coverage C (after 12 month waiting period)	50%*	60%*	N/A
Coverage D (after 12 month waiting period)	50%*	60%*	N/A
Lifetime Deductible Per Person	$100	$100	$50
Lifetime Deductible Per Family	$300	$300	$150
(Deductibles are Not Applied To Coverages A and D)			
Calendar Year Maximum for Coverages A, B, C	$1,500 up to $3,000 Per Person with Double-Up Max℠	$1,200 up to $2,400 Per Person with Double-Up Max℠	$1,000
Separate Lifetime Maximum For Coverage D	$1,500 Per Person	$1,200 Per Person	N/A

*** Benefit percentages shown are based upon the actual charges submitted up to the Maximum Allowable Charge for participating dentists, or Delta Dental's allowance for nonparticipating dentists.**

MONTHLY RATES (Valid 1/1/20 - 12/31/20):			# ENROLLED	AMOUNT DUE
Plan Option 1 PPO plus Premier Network	One Person (Single):	$50.00 X	_____	= $ _____
	Two Person:	$91.00 X	_____	= $ _____
	Three or More Persons (Family):	$152.00 X	_____	= $ _____
			TOTAL	$ _____
Plan Option 2 PPO Network	One Person (Single):	$40.00 X	_____	= $ _____
	Two Person:	$70.00 X	_____	= $ _____
	Three or More Persons (Family):	$111.00 X	_____	= $ _____
			TOTAL	$ _____
Plan Option 3 PPO plus Premier Network	One Person (Single):	$30.00 X	_____	= $ _____
	Two Person:	$50.00 X	_____	= $ _____
	Three or More Persons (Family):	$90.00 X	_____	= $ _____
			TOTAL	$ _____

Payment due with Application. Make checks payable to VACEplus Insurance Program. After the first month, VACEplus Insurance Program invoices the premiums monthly.

_____

Employer Representative Signature | Title | Date

Requested Effective Date of Dental Program: _____

Selling Agent: _____

Name | Agency | Address | Telephone

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

Authorized Signature of Employer: _____

(Please submit this application along with your enrollment forms and payment)

Northeast Delta Dental/VACE Only: NEDD Group # - 7151 **Verification of Chamber Membership:** _____