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 Option 1 - PPO plus Premier Network Copayment**	**Plan Option 2 - PPO Network Copayment**
Coverage A	100%*	100%*
Coverage B (after 6 month waiting period)	80%*	60%*
Coverage C (after 12 month waiting period)	50%*	60%*
Coverage D (after 12 month waiting period)	50%*	60%*
Lifetime Deductible Per Person	$100	$100
Lifetime Deductible Per Family	$300	$300
(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 Per Person
Separate Lifetime Maximum For Coverage D	$1,500 Per Person	$1,200 Per Person

***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 through 12/31/17**	**Plan Option 1 - PPO plus Premier Network**			**Plan Option 2 - PPO Network**		
		# Enrolled	Amount Due		# Enrolled	Amount Due
One Person (Single):	$49.00 X	_____	= $ _____	$39.00 X	_____	= $ _____
Two Person:	$89.00 X	_____	= $ _____	$69.00 X	_____	= $ _____
Three or More Persons (Family):	$149.00 X	_____	= $ _____	$109.00 X	_____	= $ _____
	TOTAL		$ _____	**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:** _____