



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



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	Plan Option 2 - PPO Network
	Copayment	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 SM	\$1,200 Per Person up to \$2,400 with Double-Up Max SM
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 1/1/2019 - 12/31/19	Plan Option 1 - PPO plus Premier Network		Plan Option 2 - PPO Network	
	# Enrolled	Amount Due	# Enrolled	Amount Due
One Person (Single):	\$50.00 X _____	= \$ _____	\$40.00 X _____	= \$ _____
Two Person:	\$91.00 X _____	= \$ _____	\$70.00 X _____	= \$ _____
Three or More Persons (Family):	\$152.00 X _____	= \$ _____	\$111.00 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: _____