



## 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	\$2,000 up to \$4,000 Per Person with Double-Up Max <sup>SM</sup>	\$1,200 up to \$2,400 Per Person with Double-Up Max <sup>SM</sup>	\$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.

\*\*Any applicable waiting period is waived for employees and dependents covered immediately prior to the original effective date of this plan when this plan is replacing an existing group dental policy that includes the services to which the waiting period applies. New enrollees, effective after the group's original effective date, are subject to waiting periods, unless moving from one Northeast Delta Dental plan to this Northeast Delta Dental plan with no more than one month gap in coverage. Waiting periods do not apply to eligible enrollees under nineteen (19) years of age except for orthodontic benefits.

### MONTHLY RATES (Valid 1/1/21 - 12/31/21)

Plan Option	Category	Rate	# ENROLLED	AMOUNT DUE
Plan Option 1 PPO plus Premier Network	One Person (Single):	\$48.00	X _____	= \$ _____
	Two Person:	\$87.00	X _____	= \$ _____
	Three or More Persons (Family):	\$145.00	X _____	= \$ _____
	<b>TOTAL</b>			\$ _____
Plan Option 2 PPO Network	One Person (Single):	\$40.00	X _____	= \$ _____
	Two Person:	\$70.00	X _____	= \$ _____
	Three or More Persons (Family):	\$111.00	X _____	= \$ _____
	<b>TOTAL</b>			\$ _____
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 _____	= \$ _____
	<b>TOTAL</b>			\$ _____

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)