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

DeltaVision VISION Plan

Application To Join The VACEplus Insurance Program DeltaVision 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 DeltaVision.

Fax: ______________________________

EMPLOYER: ______________________________ TELEPHONE: (802) ______________

ADDRESS: ______________________________ CITY: ______________________ VT ZIP: ____________

TOWN IN WHICH BUSINESS IS PHYSICALLY LOCATED ______________________________

GROUP CONTACT: ______________________________ EMAIL: ______________________________

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

A Brief Summary of Benefits

Frame Allowance (Materials)	$180
Contact Lenses Allowance (Materials)	$180
Copay Amount Exam and Lenses	$10/$10
Frequency - Exams / Lenses or Contact Lenses / Frames	12/12/12 months

For complete benefit design please see the DeltaVision Summary of Benefits

MONTHLY RATES Effective 1-1-2023 to 12-31-2026

DeltaVision $180 $180 12/12/12		# ENROLLED	AMOUNT DUE
One Person (Single):	$10.53 X	________	= $ ________
Two Person:	$18.08 X	________	= $ ________
Three or More Persons (Family):	$32.35 X	________	= $ ________
		TOTAL	$ ________

Rates are guaranteed up to 4 years beginning 1-1-2023

Payment due with Application. Make checks payable to Northeast Delta Dental

Please submit this application to Join, Enrollment Forms, and Binder check to the Attention of Kami Cunningham, 12 Bacon Street, Suite B, Burlington, VT 05401

Requested Effective Date: ______________________________

Selling Agent Name: ______________________________ Email: ______________________

Agency: ______________________________ 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: ______________________________

Delta Dental

DeltaVision Group # - 907151 **DeltaVision Sublocation #** ________________