VACE *plus*

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

DeltaVision®

DELTA DENTAL®

Application To Join The VACEplus Insurance Program Delta Dental / 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 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:	**Delta Dental PPO Plus Premier™ Copayment**
Coverage A	100%*
Coverage B (after 6 month waiting period**)	80%*
Coverage C (after 12 month waiting period**)	50%*
Coverage D (after 12 month waiting period)	50%*
Lifetime Deductible Per Person	$100
Lifetime Deductible Per Family	$300
(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℠
Separate Lifetime Maximum For Coverage D	$1,500 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.** **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.

DENTAL RATES (Valid 1/1/2024 - 12/31/2024):		**# ENROLLED**	**AMOUNT DUE**
One Person (Single):	$49.22 X	_____	= $ _____
Two Person:	$94.22 X	_____	= $ _____
Three or More Persons (Family):	$170.19 X	_____	= $ _____
		TOTAL	$ _____

VISION PROGRAM:	
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

VISION RATES (Guaranteed until 12/31/2026):

One Person (Single):	$10.53 X	_____	= $ _____
Two Person:	$18.08 X	_____	= $ _____
Three or More Persons (Family):	$32.35 X	_____	= $ _____
		TOTAL	$ _____

Payment due with Application. Make checks payable to Northeast Delta Dental. Include the ACH Authorization form for Automatic payment. Separate checks required for dental and vision plan.

Requested Effective Date of Dental Program: _____ Vision 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 Dental Group # - 71170
DeltaVision Group # - 907151

Verification of Chamber Membership: _____