



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



Application To Join The VACE 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 VACE Insurance Program and Delta Dental Plan of Vermont.

E-Mail: _____ Fax: _____

EMPLOYER: _____ TELEPHONE: (802) _____

ADDRESS: _____ CITY: _____ VT ZIP: _____

TOWN IN WHICH BUSINESS IS PHYSICALLY LOCATED _____

MEDICAL PLAN: _____ GROUP CONTACT: _____
 (for Coordination of Benefits)

DENTAL PROGRAM:

	Copayment	Waiting Period
Coverage A	* 100%	None
Coverage B	* 80%	6 months
Coverage C	* 50%	12 months
Coverage D	* 50%	24 months
Lifetime Deductible Per Person		\$100
Lifetime Deductible Per Family		\$300

See reverse side for details

Deductibles are Not Applied To Coverages A and D

Calendar Year Maximum for Coverages A, B, C\$1,500 Per Person
 Separate Lifetime Maximum For Coverage D\$1,500 Per Person

Benefit percentages shown are based upon the actual charge submitted to a maximum of the participating dentist's approved fees, or Northeast Delta Dental's allowance for non-participating dentists.

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

Minimum Employer Contribution: There is no minimum employer contribution for this program.

			# Enrolled		Monthly Premium
Monthly Rates:	One Person (Single):	\$50.00	X	_____	= \$ _____
	Two Person:	\$86.00	X	_____	= \$ _____
	Three or More Persons (Family):	\$148.00	X	_____	= \$ _____
				Total =	\$ _____

Make checks payable to VACE Insurance Program

Prior Dental Coverage: _____ *(Attach copy of prior Dental Plan Benefit Booklet)*

VACE Insurance Program invoices the premiums monthly. Rates are valid through 12-31-2010.

 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's 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 NEDD Sublocation # - 1001

Verification of Chamber Membership: _____

