



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
<b>Monthly Rates:</b>	One Person (Single):	\$50.00	X	_____	= \$ _____
	Two Person:	\$86.00	X	_____	= \$ _____
	Three or More Persons (Family):	\$148.00	X	_____	= \$ _____
				<b>Total =</b>	<b>\$ _____</b>

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:** \_\_\_\_\_

