



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):	\$52.00	X	_____	= \$ _____
	Two Person:	\$89.00	X	_____	= \$ _____
	Three or More Persons (Family):	\$154.00	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 12-31-2011.**

\_\_\_\_\_  
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: \_\_\_\_\_

## Group # 7151

Diagnostic/Preventive Coverage A	Basic Restorative Coverage B	Major Restorative Coverage C	Orthodontics Coverage D
<b>Deductible:</b> None	<b>Deductible:</b> \$100 Lifetime Deductible Per Person (\$300 Per Family)		<b>Deductible:</b> None
<b>Diagnostic:</b> <ul style="list-style-type: none"> <li>• Evaluations once in a 6-month period</li> <li>• Full mouth/panorex X-rays once in a 3-year period</li> <li>• Bite wing X-rays once each 12-month period</li> <li>• X-rays of individual teeth as necessary</li> <li>• Oral cancer screening once in a 12-month period</li> </ul> <b>Preventive:</b> <ul style="list-style-type: none"> <li>• Cleanings once in a 6-month period</li> <li>• Fluoride once in a 12-month period to age 19</li> <li>• Space maintainers to age 16</li> <li>• Sealant application to permanent molars once in a 3-year period per tooth for children to age 19</li> </ul>	<b>Restorative:</b> Fillings  <b>Oral Surgery:</b> Extractions and other surgical procedures  <b>Endodontics:</b> Root canal therapy  <b>Periodontics:</b> <ul style="list-style-type: none"> <li>• Treatment of gum disease</li> <li>• Periodontal prophylaxis (cleaning)</li> </ul> <b>Denture Repair:</b> Repair of removable dentures  <b>Clinical Crown Lengthening:</b> Once per lifetime per site  <b>Emergency Treatment</b>	<b>Prostodontics:</b> <ul style="list-style-type: none"> <li>• Removable and fixed partial dentures (bridge)</li> <li>• Complete denture</li> <li>• Rebase and reline (denture)</li> <li>• Crowns</li> <li>• Onlays</li> <li>• Implants</li> </ul>	<b>Orthodontics:</b> Correction of malposed (crooked) teeth for adults and children
<b>Northeast Delta Dental Pays 100%</b>	<b>After a 6-Month Waiting Period, Northeast Delta Dental Pays 80%</b>	<b>After a 12-Month Waiting Period, Northeast Delta Dental Pays 50%</b>	<b>After a 24-Month Waiting Period, Northeast Delta Dental Pays 50%</b>
<b>Calendar Year Maximum:</b> \$1,500 per person (Coverages A, B, and C)			<b>Lifetime Maximum:</b> \$1,500

This is an outline. Please refer to your Northeast Delta Dental Plan Description booklet for complete benefit information. 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.

Northeast Delta Dental Customer Service  
603-223-1234  
800-832-5700

VACE Insurance Customer Service  
802-229-2231  
vacehealth@vtchamber.com