



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: _____

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):	\$43.00	X	_____ = \$ _____
	Two Person:	\$71.00	X	_____ = \$ _____
	Three or More Persons (Family):	\$114.00	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 12-31-2007.

 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: _____



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Group # 7151

DEDUCTIBLE: \$100 Lifetime Deductible Per Person (\$300 Per Family) - Not Applied to Coverages A or D.

Coverage A

- Diagnostic:**
- Evaluations once in a 6-month period
 - Full mouth/panorex X-rays once in a 3-year period
 - Bite wing X-rays once each 12-month period
 - X-rays of individual teeth as necessary
- Preventive:**
- Cleanings once in a 6-month period
 - Fluoride once in a 12-month period to age 19
 - Space maintainers to age 16
 - Sealants for children to age 15 on permanent teeth

**Northeast Delta
 Dental Pays 100%**

Coverage B

- Restorative:** Fillings
- Oral Surgery:** Extractions and other surgical procedures
- Endodontics:** Root canal therapy
- Periodontics:** Treatment of gum disease; Periodontal prophylaxis (cleaning)
- Denture Repair:** Repair of removable dentures
- Emergency Treatment**

**After a 6-Month Waiting
 Period, Northeast Delta
 Dental Pays 80%**

Coverage C

- Prosthodontics:**
- Removable and fixed partial dentures (bridge); complete denture; Rebase and reline (denture); Crowns; Onlays; Implants

**After a 12-Month
 Waiting Period,
 Northeast Delta
 Dental Pays 50%**

Coverage D

Orthodontics: Correction of malposed (crooked) teeth for adults and children

**After a 24-Month
 Waiting Period,
 Northeast Delta
 Dental Pays 50%**

CALENDAR YEAR MAXIMUM: \$1,500 Per Person (Coverages A, B, C)

Lifetime Maximum: \$1,500

NEDD Customer Service
 603-223-1234
 800-832-5700

VACE Insurance Customer Service
 Telephone: 802-229-2231
 E-Mail: vacehealth@vtchamber.com

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.