



Northeast Delta Dental 800-537-1715
 One Delta Drive (603)223-1230 Eligibility
 PO Box 2002 (603)223-1252 Eligibility Fax
 Concord, NH 03302-2002 Web site: www.nedelta.com



VACE Insurance Program

Please mail to:

VACE Insurance Program
 PO Box 810
 Montpelier, VT 05601-0810
 Telephone: 802-229-2231
 Fax: 802-223-4257
 E-mail: vacehealth@vtchamber.com

ENROLLMENT / CHANGE FORM

PLEASE PRINT LEGIBLY OR TYPE - IN BLUE OR BLACK INK ONLY
 AS YOUR ID CARD IS GENERATED FROM THIS FORM

1. SUBSCRIBER INFORMATION - To be completed by Employee

LAST NAME (SUBSCRIBER)	FIRST NAME	SOCIAL SECURITY / I.D. # - -	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH (MM-DD-YYYY) MM - DD - YYYY
MAILING ADDRESS		CITY	STATE	ZIP
				TELEPHONE NO. ()
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Other _____				

2. GROUP INFORMATION - To be completed by Employer/Employee

GROUP NAME	STREET ADDRESS, CITY, STATE, ZIP			
GROUP NUMBER 7151	SUBLOCATION NUMBER 1001	DIVISION	DENTAL EFFECTIVE DATE MM - DD - YYYY	
MISC. INFO (i.e. STORE LOC)	EMPLOYEE DATE OF HIRE MM - DD - YYYY	EMPLOYEE DATE OF REHIRE MM - DD - YYYY		

3. REASON FOR SUBMISSION - Check all appropriate boxes

EXACT DATE OF STATUS CHANGE: MM - DD - YYYY	MISCELLANEOUS CHANGE:
ADD: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Annual Open Enrollment <input type="checkbox"/> COBRA Due to: _____ <input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Age Two <input type="checkbox"/> Adoption* <input type="checkbox"/> Spouse's employment change <input type="checkbox"/> Part-time to full-time status	<input type="checkbox"/> Name change - Previous name: _____ <input type="checkbox"/> Transfer from sublocation _____ <input type="checkbox"/> Address change <input type="checkbox"/> Returning Full-Time Student <input type="checkbox"/> Other _____
DELETE: <input type="checkbox"/> Annual Open Enrollment <input type="checkbox"/> Spouse's employment change <input type="checkbox"/> Full-time to part-time status <input type="checkbox"/> Divorce <input type="checkbox"/> Deceased <input type="checkbox"/> No longer dependent for IRS purposes <input type="checkbox"/> No longer a full-time student <input type="checkbox"/> Retirement	COVERAGE LEVEL REQUESTED: <input type="checkbox"/> Employee (only) <input type="checkbox"/> Employee/Children <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Family <input type="checkbox"/> Employee/Child <input type="checkbox"/> Other _____

4. DEPENDENT INFORMATION - List all dependents to be newly enrolled, or those dependents who are affected by an addition or deletion listed above in section #3. If you are enrolling some but not all of your eligible dependents, your other dependents must have coverage elsewhere.

LAST NAME (IF DIFFERENT FROM SUBSCRIBER)	FIRST NAME	DATE OF BIRTH MM-DD-YYYY	GENDER M/F	RELATION TO SUBSCRIBER	ADD / DELETE	CHECK IF DEPENDENT IS OVER 19 AND A FULL-TIME STUDENT	CHECK IF DEPENDENT IS INCAPACITATED*

*NOTE: Legal documentation is required.

5. OTHER GROUP COVERAGE (COORDINATION OF BENEFITS)

Will you, your spouse, or any dependent be covered under any other group dental plan while this policy is in effect? Yes No
 Will this dental coverage replace another Northeast Delta Dental Plan? Yes No

If yes to either question, complete the following:

DENTAL INSURANCE COMPANY	POLICY HOLDER ID # / SOCIAL SECURITY #	EFFECTIVE DATE MM - DD - YYYY
DENTAL INSURANCE COMPANY	POLICY HOLDER ID # / SOCIAL SECURITY #	EFFECTIVE DATE MM - DD - YYYY

I certify that all information is true and correct to the best of my knowledge. I understand that by not choosing a network dentist for myself or any family member, I may be responsible for higher out-of-pocket expenses. I also understand that the effective date and termination date of my membership will be determined by my employer or plan sponsor in accordance with the underwriting guidelines of Northeast Delta Dental. If my employer or plan sponsor requires employee contributions for this coverage, I authorize the deductions of these amounts from my wages. I further authorize my employer or plan sponsor to deduct any dental premium which is owed by me as of the date my application is approved. I understand that my dependents and I must remain enrolled and can discontinue our coverage only during open enrollment, except in the event of a qualified family status change.

SIGNATURE _____ DATE _____