



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):	\$50.00	X _____ =	\$ _____
	Two Person:	\$81.00	X _____ =	\$ _____
	Three or More Persons (Family):	\$130.00	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 12-31-2009.

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: _____

**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.