



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

**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 19 on permanent teeth replaceable every 3 years

**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](mailto: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.