



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 nonparticipating 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):	\$52.00	X	_____	= \$ _____
	Two Person:	\$89.00	X	_____	= \$ _____
	Three or More Persons (Family):	\$154.00	X	_____	= \$ _____
				Total =	\$ _____

Make checks
payable to
VACE
Insurance
Program

Prior Dental Coverage: _____ *(Attach copy of prior Dental Plan Benefit Booklet and prior month's invoice)*

VACE Insurance Program invoices the premiums monthly. Rates are valid through 12-31-2013.

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

This is an outline. Please refer to your Northeast Delta Dental Certificate of Insurance 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 nonparticipating dentists.

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

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