DELTA DENTAL

Application To Join
The Vermont Retail & Grocers Association Delta Dental Plan

VRGA VERMONT RETAIL & GROCERS ASSOCIATION

Acceptance of this Application makes the Employer a Participating Employer subject to the terms and conditions of the Contract between Vermont Retail & Grocers Association and Delta Dental Plan of Vermont.

Employer: _____ Effective Date: _____

Address: _____ City: _____ , VT ZIP: _____

Phone: (802) _____ Fax: _____ Broker: _____

Group Contact: _____ Group Contact Email: _____

	☐ Plan 1	☐ Plan 2	☐ Plan 3	☐ Plan 4
Coverage A	100%	100%	100%	100%
Coverage B (After a 6-month waiting period)	60%	80%	70%	80%
Coverage C (After a 12-month waiting period)	50%	50%	50%	50%
Deductible per person per calendar year	$50	$50	$50	$0
Deductible per family per calendar year	$150	$150	$150	$0
Deductible applied to Coverage A	No	No	No	No
Maximum per person per calendar year	$750	$1,500	$1,000	$2,000
Coverage D Orthodontics	N/A	50%	N/A	50%
Lifetime maximum per patient	N/A	$1,500	N/A	$2,000
Coverage D for adults	N/A	Yes	N/A	Yes
Waiting period on Coverage D	N/A	12 months	N/A	12 months

Benefit percentages shown are based upon the actual charge submitted up to a maximum allowable charge for participating dentists, or Northeast Delta Dental's allowance for nonparticipating dentists. Waiting periods do not apply to eligible enrollees under nineteen (19) years of age except for orthodontic benefits.

Will this program replace another dental program? ☐ Yes ☐ No If Yes, carrier name: _____
(Attach a copy of prior carrier's dental benefit book and prior month's invoice)

Eligibility (Probationary) Period: First day of the month following _____ months. There is no minimum employer premium contribution for this program.

Plan 1 - PPO plus Premier Low

Monthly Rates:			# Enrolled	Monthly Premium
	One Person (Single):	$46.93 X	_____	= $ _____
	Two Persons:	$89.87 X	_____	= $ _____
	Three or More Persons (Family):	$155.14 X	_____	= $ _____
			Total:	**$** _____ **(Include with Application)**

Plan 2 - PPO plus Premier High

Monthly Rates:			# Enrolled	Monthly Premium
	One Person (Single):	$63.15 X	_____	= $ _____
	Two Persons:	$122.17 X	_____	= $ _____
	Three or More Persons (Family):	$221.57 X	_____	= $ _____
			Total:	**$** _____ **(Include with Application)**

Plan 3 - PPO Low

Monthly Rates:			# Enrolled	Monthly Premium
	One Person (Single):	$45.29 X	_____	= $ _____
	Two Persons:	$86.79 X	_____	= $ _____
	Three or More Persons (Family):	$150.53 X	_____	= $ _____
			Total:	**$** _____ **(Include with Application)**

Plan 4 - PPO High

Monthly Rates:			# Enrolled	Monthly Premium
	One Person (Single):	$60.35 X	_____	= $ _____
	Two Persons:	$116.93 X	_____	= $ _____
	Three or More Persons (Family):	$210.77 X	_____	= $ _____
			Total:	**$** _____ **(Include with Application)**

☐ New group joining Delta Dental. ☐ Group transferring between options on May 1 of each year.

If transferring between options, Current Group Number: _____ - _____

Northeast Delta Dental invoices the premiums monthly. Please contact Charlotte Clark of The Richards Group at 802-251-1877 regarding the calculation of your initial premium amount. Rates effective 5/1/2024.

Group Representative Signature _____ Title _____ Date _____

Delta/Vermont Retail & Grocers Association Only: Delta Group **# 7643** Delta Sublocation # - _____

Effective Date of Dental Program: _____ Accepted By: _____

For **new** groups: Please submit this application along with your enrollment forms and payment to Charlotte Clark, The Richards Group, 48 Harris Place, Brattleboro, VT 05301. Make checks payable to **Northeast Delta Dental**. *For groups transferring between options during VRGA's annual open enrollment, please submit this form to Northeast Delta Dental, 12 Bacon Street, Suite B, Burlington, VT 05401.* For questions, please contact Tim Vartanian at 802-658-7839 or tvartanian@nedelta.com