DELTA DENTAL

VRGA VERMONT RETAIL & GROCERS ASSOCIATION

Application To Join
The Vermont Retail & Grocers Association DeltaVision Plan

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:_____

Group Contact:_____ Group Contact Email: _____

	Plan 1	Plan 2	Plan 3
Allowances:			
Frames	$180	$150	$130
Contacts	$180	$150	$130
Frequency (in months)			
Examination	12	12	12
Lenses or Contact Lenses	12	12	12
Frame	24	24	24
Copayments			
Exams	$!0	$!0	$!0
Lenses	$25	$25	$25

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

DeltaVision Plan 1 - $180 allowance

			# Enrolled	Monthly Premium
Monthly Rates:	One Person (Single):	$7.64 X	_____	= $ _____
	Two Persons:	$13.12 X	_____	= $ _____
	Three or More Persons (Family):	$23.47 X	_____	= $ _____
			Total:	**$_____(Include with Application)**

DeltaVision Plan 2 - $150 allowance

			# Enrolled	Monthly Premium
Monthly Rates:	One Person (Single):	$6.86 X	_____	= $ _____
	Two Persons:	$11.76X	_____	= $ _____
	Three or More Persons (Family):	$21.05 X	_____	= $ _____
			Total:	**$_____(Include with Application)**

DeltaVision Plan 3 - $130 allowance

			# Enrolled	Monthly Premium
Monthly Rates:	One Person (Single):	$5.95 X	_____	= $
	Two Persons:	$10.20X	_____	= $ _____
	Three or More Persons (Family):	$18.26 X	_____	= $ _____
			Total:	**$_____(Include with Application)**

☐ New group joining DeltaVision ☐ Group transferring between DeltaVision options on May 1 of each year. If transferring between DeltaVision options, Please provide your sublocation # Group Number: 907643 - _____

Northeast Delta Dental invoices premiums monthly. Please contact Vermont Retail & Grocers Association at 1-802-839-1931 regarding the calculation of your initial premium amount. Rates are effective 5/1/2022.

Group Representative Signature_____ Title_____ Date_____

Delta/Vermont Retail & Grocers Association Only: DeltaVision Group # **907643** Delta Sublocation# - _____

Effective Date of Dental Program:_____ Accepted By:_____

For **new** groups: Please submit this application along with your enrollment forms and payment to Vermont Retail & Grocers Association, 963 Paine Turnpike North, Unit 2, Berlin, VT 05602. 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

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