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.

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):	$39.34 X	_____	= $ _____
	Two Persons:	$75.33 X	_____	= $ _____
	Three or More Persons (Family):	$130.05 X	_____	= $ _____
			Total:	**$** _____ **(Include with Application)**

Plan 2 - PPO plus Premier High

Monthly Rates:			# Enrolled	Monthly Premium
	One Person (Single):	$52.94 X	_____	= $ _____
	Two Persons:	$102.41 X	_____	= $ _____
	Three or More Persons (Family):	$185.73 X	_____	= $ _____
			Total:	**$** _____ **(Include with Application)**

Plan 3 - PPO Low

Monthly Rates:			# Enrolled	Monthly Premium
	One Person (Single):	$37.96 X	_____	= $ _____
	Two Persons:	$72.75 X	_____	= $ _____
	Three or More Persons (Family):	$126.19 X	_____	= $ _____
			Total:	**$** _____ **(Include with Application)**

Plan 4 - PPO High

Monthly Rates:			# Enrolled	Monthly Premium
	One Person (Single):	$50.59 X	_____	= $ _____
	Two Persons:	$98.02 X	_____	= $ _____
	Three or More Persons (Family):	$176.68 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 Vermont Retail & Grocers Association at 1-802-839-1931 regarding the calculation of your initial premium amount. Rates effective 5/1/2020.

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 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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