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	$10	$10	$10
Lenses	$25	$25	$25

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

Domestic Partner Coverage ☐ Yes ☐ No

DeltaVision Plan 1 - $180 allowance

Monthly Rates:			# Enrolled	Monthly Premium
	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

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

DeltaVision Plan 3 - $130 allowance

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

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

If transferring between DeltaVision options, Current Group Number: **907643 -** ____________

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 5/1/2023.

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 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