

Application To Join The Vermont Truck & Bus Association, Inc. Delta Dental Plan

Completion of this Application makes the Employer a Participating Member Employer subject to the terms and conditions of the contract between Vermont Truck & Bus Association, Inc. and Northeast Delta Dental. This includes being a member in good standing.

EMPLOYER: _____ EFFECTIVE DATE OF PROGRAM: _____

ADDRESS: _____ CITY: _____, VT ZIP: _____

TELEPHONE: (603) _____ FAX: _____ E-MAIL: _____

MEDICAL CARRIER: _____ GROUP CONTACT: _____

PRIOR DENTAL COVERAGE? [] YES [] NO IF YES, CARRIER NAME: _____

(Attach copy of prior dental plan benefit booklet) **CHECK ONE ONLY:** Option 1* [] Option 3 [] Option 5 [] Option 6* [] Option 7* []

Coverage A	100%	100%	100%	100%	100%
Coverage B (After a 6-month waiting period)	80%	80%	60%	80%	80%
Coverage C (After a 12-month waiting period)	50%	50%	50%	50%	50%
Coverage D (After a 24-month waiting period)	50%	50%	N/A	50%	N/A
Lifetime Deductible Per Person/Family	\$100/\$300	\$100/\$300	\$75/\$225	\$100/\$300	\$100/\$300
Calendar Year Maximum for Coverages A, B, C	\$2,000	\$1,000	\$1,500	\$2,000	\$2,000
Separate Lifetime Maximum For Coverage D (per child and adult) ...	\$2,000	\$1,000	N/A	\$2,000	N/A

*Option 1 includes a Carryover Benefit feature; please refer to the Carryover Benefit flyer for more details.

*Options 6 and 7 exclude Diagnostic and Preventive Services from annual maximum.

Eligibility (Probationary) Period: First day of the month following _____

Option 1

		# Enrolled	Monthly Premium
Monthly Rates: One Person (Single):	\$50.25	X _____	= \$ _____
Two Persons:	\$87.23	X _____	= \$ _____
Three or More Persons (Family):	\$154.78	X _____	= \$ _____
Total First Month's Premium Due			\$ _____

Option 3

		# Enrolled	Monthly Premium
Monthly Rates: One Person (Single):	\$46.98	X _____	= \$ _____
Two Persons:	\$80.26	X _____	= \$ _____
Three or More Persons (Family):	\$132.85	X _____	= \$ _____
Total First Month's Premium Due			\$ _____

Option 5

		# Enrolled	Monthly Premium
Monthly Rates: One Person (Single):	\$40.72	X _____	= \$ _____
Two Persons:	\$68.40	X _____	= \$ _____
Three or More Persons (Family):	\$104.80	X _____	= \$ _____
Total First Month's Premium Due			\$ _____

Option 6

		# Enrolled	Monthly Premium
Monthly Rates: One Person (Single):	\$46.79	X _____	= \$ _____
Two Persons:	\$81.21	X _____	= \$ _____
Three or More Persons (Family):	\$143.76	X _____	= \$ _____
Total First Month's Premium Due			\$ _____

Option 7

		# Enrolled	Monthly Premium
Monthly Rates: One Person (Single):	\$46.53	X _____	= \$ _____
Two Persons:	\$80.01	X _____	= \$ _____
Three or More Persons (Family):	\$135.78	X _____	= \$ _____
Total First Month's Premium Due			\$ _____

Above rates are guaranteed through December 31, 2021. Annual open enrollment effective January 1st each year.

Make checks payable to: VTBAI.

All applications and correspondence should be directed to VTBAI, PO Box 3898, Concord, NH 03302.

For inquiries, please contact VTBAI: Phone: 802-479-1778, Fax: 802-479-1395

Group Representative Signature Title Date

Delta/VTBAI Only

Delta Dental Group # - _____ VTBAI Store Location # - _____

Accepted By: _____