DELTA DENTAL

VERMONT TRUCK & BUS ASSOCIATION, INC.

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: (802) _____ 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):	$46.00	X	_____	= $	_____
	Two Persons:	$90.00	X	_____	= $	_____
	Three or More Persons (Family):	$160.00	X	_____	= $	_____
	Total First Month's Premium Due				$	_____

Option 3

				# Enrolled		Monthly Premium
Monthly Rates:	One Person (Single):	$47.30	X	_____	= $	_____
	Two Persons:	$80.78	X	_____	= $	_____
	Three or More Persons (Family):	$133.70	X	_____	= $	_____
	Total First Month's Premium Due				$	_____

Option 5

				# Enrolled		Monthly Premium
Monthly Rates:	One Person (Single):	$41.00	X	_____	= $	_____
	Two Persons:	$68.86	X	_____	= $	_____
	Three or More Persons (Family):	$105.41	X	_____	= $	_____
	Total First Month's Premium Due				$	_____

Option 6

				# Enrolled		Monthly Premium
Monthly Rates:	One Person (Single):	$47.09	X	_____	= $	_____
	Two Persons:	$81.73	X	_____	= $	_____
	Three or More Persons (Family):	$144.71	X	_____	= $	_____
	Total First Month's Premium Due				$	_____

Option 7

				# Enrolled		Monthly Premium
Monthly Rates:	One Person (Single):	$46.83	X	_____	= $	_____
	Two Persons:	$80.52	X	_____	= $	_____
	Three or More Persons (Family):	$136.66	X	_____	= $	_____
	Total First Month's Premium Due				$	_____

Above rates are guaranteed through December 31, 2024. 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 Dental/VTBAI Only

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

Accepted By: _____ VTBAI

_____ Northeast Delta Dental

Rev. 01/24