DELTA DENTAL®

603-223-1230 Eligibility
603-223-1252 Eligibility Fax
NortheastDeltaDental.com

VACE *plus*

ENROLLMENT / CHANGE FORM

Please mail to:
VACE Insurance Program
PO Box 810
Montpelier, VT 05601-0810
Telephone: 802-229-2231
Fax: 802-223-4257
E-mail: vacehealth@vtchamber.com

1. SUBSCRIBER INFORMATION

LAST NAME (SUBSCRIBER)	FIRST NAME	SOCIAL SECURITY / I.D. #	GENDER	DATE OF BIRTH (MM-DD-YYYY)
				— —

MAILING ADDRESS	CITY	STATE	ZIP	TELEPHONE NO.
				( )

MARITAL STATUS ☐ SINGLE ☐ MARRIED/CIVIL UNION PARTNER ☐ DIVORCED ☐ WIDOWED ☐ OTHER _____

E-MAIL

2. GROUP INFORMATION - To be completed by Employer/Employee

GROUP NAME / EMPLOYER NAME	STREET ADDRESS, CITY, STATE, ZIP		
GROUP NUMBER 7151	SUBLOCATION NUMBER (CIRCLE ONE) 91001 (Plan 1) 91002 (Plan 2) 91003 (Plan 3)	DIVISION	DENTAL EFFECTIVE DATE — —
VACE ID NUMBER	EMPLOYEE DATE OF HIRE — —	EMPLOYEE DATE OF REHIRE — —	PLAN SELECTION: ☐ Plan 1 ☐ Plan 2 ☐ Plan 3

3. REASON FOR ENROLLMENT/CHANGE:

EXACT DATE OF STATUS CHANGE — — (MM-DD-YYYY) _____

ADD:
- ☐ New enrollment
- ☐ Annual open enrollment
- ☐ COBRA Due to:
- ☐ Marriage/Civil union
- ☐ Birth ☐ Other:
- ☐ Adoption*
- ☐ Employment change for spouse/civil union partner/domestic partner
- ☐ Part-time to full-time employment status

DELETE:
- ☐ Annual open enrollment
- ☐ Employment change for spouse/civil union partner/domestic partner
- ☐ Full-time to part-time employment status
- ☐ Divorce/Termination of a civil union
- ☐ Deceased
- ☐ No longer dependent for IRS purposes
- ☐ Retirement
- ☐ Other_____

MISCELLANEOUS CHANGE:
- ☐ Name change – Previous name: _____
- ☐ Transfer from sublocation: _____
- ☐ Address change
- ☐ Other: _____

COVERAGE LEVEL REQUESTED
- ☐ Employee Only ☐ Employee & Spouse/Civil union partner ☐ Employee & Child
- ☐ Employee & Children ☐ Family

4. DEPENDENT INFORMATION - List all dependents to be newly enrolled, or those dependents who are affected by an addition or deletion listed above in section #3. If you are enrolling some but not all of your eligible dependents, your other dependents must have coverage elsewhere.

LAST NAME	FIRST NAME	DATE OF BIRTH mm/dd/yyyy	SEX M/F	RELATION TO SUBSCRIBER	*	ADD/ DELETE	E-MAIL FOR SPOUSE AND/OR DEPENDENTS OVER THE AGE OF 14**

*Check if dependent is incapacitated. Legal documentation may be required.

5. OTHER GROUP COVERAGE (COORDINATION OF BENEFITS)

Will you, your spouse, or any dependent be covered under any other group dental plan while this policy is in effect? ☐ Yes ☐ No
Will this dental coverage replace another Northeast Delta Dental Plan? ☐ Yes ☐ No

If yes to either question, complete the following:

DENTAL INSURANCE COMPANY	POLICY HOLDER ID # / SOCIAL SECURITY #	EFFECTIVE DATE
		— —
DENTAL INSURANCE COMPANY	POLICY HOLDER ID # / SOCIAL SECURITY #	EFFECTIVE DATE
		— —

I certify that all information is true and correct to the best of my knowledge. I understand that by not choosing a network dentist for myself or any family member, I may be responsible for higher out-of-pocket expenses. I also understand that the effective date and termination date of my membership will be determined by my employer or plan sponsor in accordance with the underwriting guidelines of Northeast Delta Dental. If my employer or plan sponsor requires employee contributions for this coverage, I authorize the deductions of these amounts from my wages. I further authorize my employer or plan sponsor to deduct any dental premium which is owed by me as of the date my application is approved. I understand that my dependents and I must remain enrolled and can discontinue our coverage only during open enrollment, except in the event of a qualified family status change.

SIGNATURE _____ DATE _____