



NORTHEAST DELTA DENTAL
GROUP CONTRACT APPLICATION
FOR DENTAL BENEFITS

Northeast Delta Dental
One Delta Drive
P.O. Box 2002
Concord, NH 03302-2002
800-537-1715
www.nedelta.com

Delta Dental Plan of Vermont, Inc.

GROUP INFORMATION

Name of Group: _____ Effective Date: _____
Physical Address: _____ Type of Industry: _____
City: _____ State: _____ Zip Code: _____ Anniversary Date: _____
Billing Address: _____ (Month and Day)
City: _____ State: _____ Zip Code: _____
Group Administrative Contact: _____ Title: _____
Telephone: (____) _____ Extension: _____ Fax: (____) _____ Email: _____
Group Eligibility Contact: _____ Title: _____
Telephone: (____) _____ Extension: _____ Fax: (____) _____ Email: _____

BENEFIT STRUCTURE

Table with 3 columns: Selected Copayment Percentage, Annual Maximums, and Deductibles. Includes fields for Diagnostic/Preventative, Basic, Major, Orthodontics, Children Only, Children & Adults, Annual, Lifetime, None, Individual, Family, Deductible applies to Basic & Major, Other, Calendar Year Benefits, and Contract Year Benefits.

WAITING PERIODS

*Coverage B Benefits are effective the first day of the month following the completion of _____ months of coverage
*Coverage C Benefits are effective the first day of the month following the completion of _____ months of coverage
*Coverage D Benefits are effective the first day of the month following the completion of _____ months of coverage

Waiting periods apply to:

All Employees: Future Employees:

Name of Current Dental Carrier: _____

*In group takeover situations, Northeast Delta Dental will waive the waiting periods for benefits covered by the prior carrier for continuous group coverage. This applies to employees and dependents that were enrolled in the previous carrier's plan at the time of the takeover.

ELIGIBILITY (PROBATIONARY) PERIOD FOR NEWLY HIRED EMPLOYEES

Coverage for newly hired employees is effective on the first day of the month following: _____
Other (explain) _____

EMPLOYER CONTRIBUTION

Please indicate the employer contribution towards the cost of this dental plan by checking the appropriate box and filling in the contribution percentages where appropriate.

- Voluntary (No employer contribution required)
 Contributory Employer contribution of employee cost: _____ %
Employer contribution of dependent cost: _____ %
 Fully Paid (No employee contribution)
 Tied to Medical All employees who are enrolled in the group medical plan must be enrolled in this dental plan (parallel enrollment)
 Flex _____

FOR DELTA DENTAL USE ONLY

Group Number: _____ Sublocation Number: _____ Division Number: _____

FULLY INSURED RATE STRUCTURE

2-Tier Rate and 3-Tier Rate Structure: Subscriber: \$ _____ Subscriber / Spouse \$ _____ Family: \$ _____
/*Civil Union Partner or Subscriber / Child:

4-Tier Rate Structure: Subscriber: \$ _____ Subscriber / Spouse \$ _____ Subscriber + Child(ren): \$ _____ Family: \$ _____
/*Civil Union Partner:

Other Rate Structure: Please specify: _____

Rate Guarantee (no. of months): _____
* VT Only

CENSUS AND BILLING INFORMATION

Number of Membership Types:	Monthly Rate	Total Premium	Billing Method
Subscriber: _____ X	\$ _____	= \$ _____	<input type="checkbox"/> Monthly Invoice
Subscriber / Spouse or / Civil Union Partner: _____ X	\$ _____	= \$ _____	<input type="checkbox"/> Monthly Electronic Funds Transfer (EFT)
Subscriber / Child: _____ X	\$ _____	= \$ _____	If electing (EFT) a completed Payment Option Form must be included with this application
Subscriber / Children: _____ X	\$ _____	= \$ _____	
Family: _____ X	\$ _____	= \$ _____	
Total Number of Employees: _____ Include First Monthly Payment of: \$ _____			

PRODUCER INFORMATION

Producer Name: _____ Agency Name: _____
 Street Address: _____ Tax ID #: _____
 City: _____ Commissions To: Producer Agency
 State: _____ Zip: _____ Contracts To: Producer Group
 Producer Email Address: _____ Renewals To: Producer Group
 Telephone: () _____ Fax : () _____
 Producer Signature: **X** _____

ADDITIONAL PROVISIONS

As a duly authorized officer/partner/proprietor of the Applicant, I apply for the dental plan outlined above. The undersigned certifies that the Applicant (Business) is a legitimate business headquartered in the State of Vermont. This Application shall become part of the Group Contract for Dental Benefits ("Agreement") and by execution of this Application, the undersigned binds the Applicant to all of the terms of the Agreement. The Agreement shall become effective on the date referenced above (the "Effective Date"), provided Northeast Delta Dental accepts this Application. Statements in this Application are representations of the Applicant and any misrepresentations will cause the Agreement, if issued, to be voidable, at the sole option of Northeast Delta Dental. Payment of claims and determination of eligibility are contingent upon completion of this Application by the Applicant and acceptance by Northeast Delta Dental, issuance of the Agreement by Northeast Delta Dental, and receipt by Northeast Delta Dental of the first payment. On behalf of the Applicant, I understand the producer, if any, will be involved in the delivery and receipt of information relating to this Application and the Agreement. I acknowledge that said producer does not have authority to approve or change this Application or the Agreement, or to waive any of their provisions.

The policy provides dental benefits only. Review your policy carefully.

GROUP NAME: _____

FOR NORTHEAST DELTA DENTAL USE ONLY:

BY: **X** _____
(Duly Authorized Group Administrator)

DELTA DENTAL PLAN OF _____

NAME(PLEASE PRINT) _____

BY: _____

TITLE: _____

NAME: THOMAS RAFFIO
TITLE: PRESIDENT & CEO

DATE: _____

DATE: _____