



Dental Plan Selection Form

CONTACT PERSON

Please print the name of the adult from Step 1 of your "Application for Health Coverage."

FIRST AND LAST NAME (PLEASE PRINT): _____

MARITAL STATUS: _____ DATE OF BIRTH (MM/DD/YYYY): _____

Marital status: M-Married, NM-Never Married, W-Widowed, LS-Legally Separated, SEP-Separated, D-Divorced, DP-Domestic Partner, CU-Civil Union

Please note: Please consult Vermont Health Connect's plan comparison brochures, the insurance companies' Summaries of Benefits and Coverage (SBC), and VermontHealthConnect.gov to be sure you are clear on the plan details before making your selection. For a free copy of an SBC for one or more dental plans, please call Delta Dental (1-800-832-5700).

Stand Alone Dental Tier and Plan Selection

Step 1: Please choose your tier by checking the circle to the left.

	VT Rate Tier Level	VT Tier Title	Definition – Individual Dental
<input type="radio"/>	Tier I	Single	One person – the subscriber (must be an adult)
<input type="radio"/>	Tier II	Two Person	A couple (two persons age 21+ who are married to each other or are in a civil union, according to the rules of Vermont), or an adult (21+) with an adult child age 21 through 26
<input type="radio"/>	Tier III	Single Head of Household (HoH)	One adult subscriber (age 21+) and one or more dependent child(ren) under the age of 21
<input type="radio"/>	Tier IV	Family	A couple (two persons age 21+ who are married to each other or are in a civil union, according to the rules of Vermont) with child(ren) up to age 26, or an adult subscriber (age 21+) with two or more children, at least one of whom is an adult child age 21 through 26
<input type="radio"/>	Stand Alone Pediatric Dental (SA-PD)	One person – the subscriber (must be a child under the age of 21)	Stand Alone Pediatric Dental (SA-PD)

NOTES FROM VERMONT DEPARTMENT OF FINANCIAL REGULATION (DFR):

- Children under age 21 receive pediatric dental coverage when enrolled in a Qualified Health Plan
- Children are eligible for SA-PD through the last day of the benefit year in which they turn 21
- Children over the age of 26 may be covered if deemed incapacitated dependents
- Dependent children include: biological children, adopted children, step-children, and children for whom subscriber is legal guardian

Step 2: Please choose your plan by checking the circle to the left.

Important note: Pediatric Dental (up to the end of the calendar year in which the child turns 21) is **included in Qualified Health Plans** offered through Vermont Health Connect (see “Medical Plan Selection Form”), although the deductibles and benefits of those plans differ from the Stand Alone Dental Plans described below (please consult Vermont Health Connect’s dental plan brochure or Delta Dental’s Summaries of Benefits and Coverage). When making your selection below, **ONLY** include children for whom you’d like to purchase a Stand Alone Dental Plan.

	Stand Alone Dental Plan	Tier	Monthly Premium
<input type="radio"/>	Adult Plan	Single	\$ 46.93
		Couple	\$ 89.62
<input type="radio"/>	High Pediatric Option \$50 Adult Deductible (per person) \$50 Pediatric Ded. (per person)	HoH	\$ 122.12
		Family	\$ 165.34
		SA-PD (Rate per Child)	\$ 38.64
<input type="radio"/>	Low Pediatric Option \$50 Adult Deductible (per person) \$625 Pediatric Ded. (per person)	HoH	\$ 110.74
		Family	\$ 160.34
		SA-PD (Rate per Child)	\$ 32.79
<input type="radio"/>	I decline dental coverage.		

Step 3: Please list the members of the family who will be insured on the dental plan.

***Please note:** All members on this plan should also be included in the “Application for Health Coverage.”

Relationship to Contact	Name	Date of Birth (mm/dd/yyyy)
Self		
Second Adult		
Dependent		

Step 4: Please write the month in which you would like coverage to begin.

Month: _____ (should be at least one full month from application date, if using paper application)

Step 5: Please tell us how you heard about Vermont Health Connect.

- Employer
- Friends/Family
- Internet
- Mail
- News
- Other: _____

Step 6: Read and sign this form.

I understand that, by signing this document, I have reviewed the Summary of Benefits and Coverage for my plan and understand its terms and conditions. I also understand that financial assistance is not available for Dental Benefits.

Signature	Date (mm/dd/yyyy)
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Mail completed and signed form to:
Vermont Health Connect, 103 South Main Street, Waterbury, VT 05671-8100