BHE DENTAL PLANS

hpi

# 2026 Open Enrollment
# MetLife Dental Insurance Enrollment/Change Form
# BHE Non-Unit Higher Education Health and Welfare Fund

The Trustees of the Non-Unit Higher Education Health and Welfare Fund are offering the members an indemnity dental plan. In order to participate in the plan, I will have to make a payroll contribution based on the coverage I select. I may also choose not to participate in this dental plan. By completing and signing this form, I am informing the Trustees of my election. I understand that my **coverage will be effective January 1, 2026.**

## INSTRUCTIONS:

- To be completed by Non-Unit subscribers only.
- Mark the box indicating if you wish to add coverage or would like to drop coverage.
- Print all names and numbers clearly.
- **Sign the form and return it to your HR Administrator's office by October 31, 2025.**

| **COVERAGE ELECTION** | |
|---|---|
| ☐ I **DO** wish to participate in this dental plan.<br>I authorize the appropriate payroll deduction. | ☐ I **DO NOT** wish to participate in this dental plan.<br>I understand that I will not have dental insurance through my employer. |

| **CHECK OFF ALL THAT APPLY** *(if you are making an election change, check the coverage changes that apply)* | |
|---|---|
| **Coverage Requested:**<br>☐ Employee only ☐ Family | **Change in Family Status:**<br>☐ Addition of Dependent(s) ☐ Removal of Dependent(s) |

| **EMPLOYEE INFORMATION** | | | |
|---|---|---|---|
| ***Name*** | ***Employee ID#*** | ***Social Security#*** | |
| ***Address*** | ***City*** | ***State*** | ***ZIP Code*** |
| ***Primary Phone# w/ Area Code*** | ***Date of Birth (MM/DD/YYYY)*** | ***Date of Hire (MM/DD/YYYY)*** | ***Email Address*** |
| ***Place of Employment (specify campus)*** | | | |

| **DEPENDENTS** | | | | |
|---|---|---|---|---|
| ***First Name*** *(indicate Last Names only if different)* | ***Date of Birth*** | ***Social Security #*** | ***M/F*** | ***Add/Drop*** |
| ***Spouse*** | | | | |
| ***Child*** | | | | |
| ***Child*** | | | | |
| ***Child*** | | | | |
| ***Child*** | | | | |

☐ Check here if your spouse is also eligible for coverage through the Non-Unit Higher Education Health and Welfare Fund, due to employment with UMass, the Massachusetts State University System or the Massachusetts Community College System.

| **EMPLOYEE SIGNATURE** | |
|---|---|
| | ***Date*** |

For more information about the plan, visit **HealthPlansInc.com/BHE.**
**Please return this form to your Human Resources Administrator's Office by October 31, 2025.**