Clear Form

MetLife Dental Insurance Enrollment/Change Form

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.

If you do not wish to participate, you still need to submit this form. Please return this form to your Human Resources Administrator's Office.

COVERAGE ELECTION

☐ I DO wish to participate in this dental plan. I authorize the appropriate payroll deduction.	☐ I DO NOT wish to participate in this dental plan. I understand that I will not have dental insurance through my employer.

CHECK OFF ALL THAT APPLY

☐ New Hire ☐ Change of Name *Provide former name:* _____

☐ New Address ☐ Prior Service/Transfer from another Institution *Provide former institution:*

Change in Status-Special Handling:	Change in Family Status:
☐ Waive Waiting Period *Coverage Start Date:* _____	☐ Addition of Dependent(s) *Effective Date:* _____
Reason: _____	*Reason:* _____
	☐ Removal of Dependent(s) *Effective Date:* _____
	Reason:

Coverage Requested: ☐ Employee only ☐ Family

EMPLOYEE INFORMATION

Name	*Employee ID #*	*Social Security #*	
Street	*City*	*State*	*ZIP Code*
Phone #	*Date of Birth*	*Date of Hire*	
Work Email Address (required):			
Place of Employment (specify campus): University of Massachusetts Amherst			

DEPENDENTS

First Name (indicate Last Names only if different)	Date of Birth	Social Security #	M/F
Spouse			
Child			
Child			
Child			
Child			

SIGNATURE

Employee Signature	Date

For more information about the plan, visit HealthPlansInc.com/BHE

HR Administrators may send via: Fax: 508-795-1933 | Email: BHEeligibilityquestions@HealthPlansInc.com| Mail: Health Plans, Inc. · P.O. Box 5199 · Westborough, MA 01581