



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.

COVERAGE ELECTION			
<input type="checkbox"/> I DO wish to participate in this dental plan. I authorize the appropriate payroll deduction.	<input type="checkbox"/> 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			
<input type="checkbox"/> New Hire	<input type="checkbox"/> Change of Name <i>Provide former name:</i> _____		
<input type="checkbox"/> New Address	<input type="checkbox"/> Prior Service/Transfer from another Institution <i>Provide former institution:</i> _____		
Change in Status-Special Handling:		Change in Family Status:	
<input type="checkbox"/> Waive Waiting Period <i>Coverage Start Date:</i> _____		<input type="checkbox"/> Addition of Dependent(s) <i>Effective Date:</i> _____	
<i>Reason:</i> _____		<i>Reason:</i> _____	
<input type="checkbox"/> Removal of Dependent(s) <i>Effective Date:</i> _____		<i>Reason:</i> _____	
Coverage Requested: <input type="checkbox"/> Employee only <input type="checkbox"/> Family			
EMPLOYEE INFORMATION			
<i>Name</i>		<i>Employee ID #</i>	<i>Social Security #</i>
<i>Street</i>		<i>City</i>	<i>State</i> <i>ZIP Code</i>
<i>Phone #</i>	<i>Date of Birth</i>		<i>Date of Hire</i>
<i>Work Email Address (required):</i>			
<i>Place of Employment (specify campus):</i>			
DEPENDENTS			
First Name (indicate Last Names only if different)	Date of Birth	Social Security #	M/F
<i>Spouse</i>			
<i>Child</i>			
<i>Child</i>			
<i>Child</i>			
<i>Child</i>			
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