BHE Dental Plans

HealthPlans, Inc.

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

☐ 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:

☐ Waive Waiting Period *Coverage Start Date:* _____

Reason: _____

Change in Family Status:

☐ Addition of Dependent(s) *Effective Date:* _____

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*

Place of Employment (specify campus):

DEPENDENTS

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

☐ Check here if your spouse is also employed by UMASS, the state university system or the community college system in Massachusetts and is also eligible for coverage through the Non-Unit Higher Education Health and Welfare Fund.

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