BHE DENTAL PLANS

HealthPlans, Inc.

MetLife Dental Insurance Enrollment/Change Form
MTA Higher Education Health and Welfare Fund

INSTRUCTIONS

1. To be completed by members of APA, MCCC, MSCA, MSP/FSU and USA Unions.
2. Print your name, address, the name and social security numbers of your spouse and eligible dependents.
3. Please include the name and location of your college or university.
4. Sign this application and give it to your HR office.

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 MTA Higher Education Health and Welfare Fund Dental Plan.

DECLINE COVERAGE

☐ Check here if you are declining enrollment in the plan.

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