MetLife Dental Insurance Enrollment/Change Form

MTA Higher Education Health and Welfare Fund

Instructions

Clear Form

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.

✉ HR administrators may send: By Mail: To the address below | Fax: 508-329-4812| Email: BHEeligibilityquestions@HealthPlansInc.com

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*	*Work Email Address (required):*

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			

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