

INSTRUCTIONS

1. To be completed by members of APA, MCCC, MSCA, MSP 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 drop it in the mail.

DENTAL INSURANCE ENROLLMENT/CHANGE CARD

BHE/MASSACHUSETTS TEACHERS ASSOCIATION HEALTH AND WELFARE TRUST FUND

CHECK OFF ALL THAT APPLY

New Hire

New Address Change of Name State Former Name _____

Change In Status:

Part-time to Full-time Effective Date _____
Non-Unit to Unit Effective Date _____

Change in Family Status:

Additional Dependents Reason _____ Effective Date _____
Removal of Dependents Reason _____ Effective Date _____

Name _____ Date of Birth _____ Social Security No. _____

Street _____ City _____ State _____ Zip _____

Telephone # (____) _____ Work Phone (____) _____ Date of Hire _____

Place of employment: University, State or Community College or other (specify)

Coverage Requested: Individual Family Family without Dependents

DEPENDENTS: First Name **DOB** **SS#** **M/F** **School (if age 19 or over)**
(Indicate Last Names only if different)

Spouse _____ / / _____ - - _____

Child _____ / / _____ - - _____

Child _____ / / _____ - - _____

Child _____ / / _____ - - _____

Child _____ / / _____ - - _____

Check here if your spouse is also employed by any public university, state college, or community college and is also eligible for coverage through the BHE/Dental Care Trust Fund.

Please sign here _____ DATE _____