

# 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 \_\_\_\_\_