INSTRUCTIONS

1. To be completed by Non-Unit employees.
2. Print your name, social security number for you, your spouse and dependent children, and your address and telephone number.
3. Print the name and location of your employer.
4. If you DO NOT wish to participate, YOU STILL NEED TO SUBMIT this form
5. Sign this application and return it to: Human Resources, 333 South St, Suite 450, Shrewsbury, MA 01545.

DENTAL ENROLLMENT/CHANGE CARD

BHE/NON-UNIT EMPLOYEE HEALTH AND WELFARE FUND

The Trustees of the Non-Unit Employee Health and Welfare Fund are offering the members an Indemnity dental plan as outlined in the accompanying material. In order to participate in this 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.

{ } I DO wish to participate in this dental plan.
I authorize the appropriate payroll deduction.

{ } I <u>DO NOT</u> 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 [ ] Transfer Effective Date _____

[ ] New Address [ ] Name Change/Indicate Old Name: _____ [ ] Cancel Coverage

[ ] Change in Family Status: [ ] Add Dependents Reason_____ Date _____
[ ] Remove Dependents Reason _____Date _____

Name _____Date of Birth_____/____/_____Soc. Sec. #_____

Address _____City _____State _____Zip _____

Home Phone _____Work Phone _____Date of Hire _____

Work Location: UNIVERSITY OF MASSACHUSETTS – PRESIDENT' S OFFICE

<u>Coverage Requested</u>: Individual _____ Family _____

DEPENDENTS: (Indicate last names only if different)

Name	DOB	SS#	M/F	School (If age 19 or over)
Spouse _____	____/____/____	____-_____-_____	____	_____
Child _____	____/____/____	____-_____-_____	____	_____
Child _____	____/____/____	_____-_____-_____	____	_____
Child _____	____/____/____	_____-_____-_____	____	_____
Child _____	____/____/____	_____-_____-_____	____	_____

[ ] Check here if your spouse is employed by any public university, state college or community college and is also eligible for coverage through the Non-Unit Employee Health and Welfare Fund.

EMPLOYEE'S SIGNATURE _____ DATE_____