# 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. Please include 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 your campus H.R. Department.

---

# 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 deductions.

{ } I do **NOT** 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

New Address [ ] New Name [ ] Indicate Old Name________________________

Change in Family Status:
Additional Dependents __________ Reason ________________ Date__________
Removal of Dependents __________ Reason ________________ Date__________

Change In Employment Status: Unit to Non-Unit ________ Date________________

Name__________________________ Date of Birth__________ Soc. Sec. No.__________

Address__________________ City__________ State________ Zip__________

Home Phone (___)__________ Work Phone (___)__________ Date of Hire__________

Name of University, State College or other (specify)________________________

**Coverage Requested**: Individual__________ Family__________

| **DEPENDENTS: First Name** (Indicate last names only if different) | **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 Health & Welfare Fund.

EMPLOYEE'S SIGNATURE________________________________ DATE__________