MASSACHUSETTS STATE HEALTH CARE PROFESSIONALS' DENTAL FUND

For Internal Use Only:

EFFECTIVE DATE: ___/___/____

DENTAL/VISION ENROLLMENT/CHANGE FORM

COMPLETE ALL SECTIONS BELOW

(FOR PROPER PROCESSING OF YOUR ENROLLMENT, PLEASE PRINT CLEARLY USING A BLACK BALLPOINT PEN, TO AUTOFILL ONLINE USE PDF FIL TOOL)

REASON FOR SUBMISSION (CHECK ALL THAT APPLY): ☐ **Open Enrollment** ☐ **New Hire** ☐ **Change Coverage Selection** ☐ **Add Dependents listed Below** ☐ **Change of Address** ☐ **Change of Marital Status** ☐ **Change of Name (Former Name_____)**

PLEASE SELECT THE PLAN YOU WISH TO ENROLL: **(PLEASE CHECK ONE BOX ONLY)**

☐ **STANDARD DENTAL PLAN** (FULLY PAID BY YOUR EMPLOYER)

☐ **HIGH OPTION DENTAL PLAN** (REFER TO PAYROLL DEDUCTION AUTHORIZATION SECTION)

EMPLOYEE SOCIAL SECURITY NO. | SEX(M/F) | EMPLOYEE BIRTHDATE (MM/DD/YYYY) | MARITAL STATUS (M/S/W/D/SP/CL) | EMPLOYMENT DATE (MM/DD/YYYY)

EMPLOYEE NAME: **LAST** (AS SHOWN ON YOUR PAY STUB) | **FIRST** | **MI**

HOME ADDRESS (STREET, APARTMENT NUMBER)

CITY | STATE | ZIP CODE | HOME PHONE NUMBER

CELL PHONE NUMBER | EMAIL ADDRESS

SPOUSE NAME (LAST, FIRST, MI) | SEX(M/F) | SPOUSE SOCIAL SECURITY NUMBER | SPOUSE BIRTHDATE(MM/DD/YYYY)

NAME (LAST, FIRST, MI) OF DEPENDENT CHILDREN	DEPENDENT SOC. SEC. NO.	RELATIONSHIP (S / D)	1-Natural 2-Adopted 3-Stepchild	SEX (M / F)	BIRTHDATE (MM / DD / YYYY)

YOU MUST INCLUDE COPIES OF DOCUMENTATION THAT SUPPORT YOUR DEPENDENT RELATIONSHIP (I.E. – MARRIAGE, BIRTH, ADOPTION, ETC.) AS WELL AS A PHYSICIAN STATEMENT FOR CHILDREN LISTED AS MENTALLY OR PHYSICALLY HANDICAPPED. FAILURE TO PROVIDE COMPLETE SUPPORTING DOCUMENTATION CAN RESULT IN A DELAY OF ELIGIBILITY. ATTACH ADDITIONAL COPIES OF THIS FORM FOR MORE DEPENDENTS.

The Fund and the Employee agree that this form may be electronically signed and that the electronic signature appearing on this form is the same as handwritten signatures for purposes of validity, enforceability and admissibility.

EMPLOYER PAYROLL DEDUCTION AUTHORIZATION OR AUTHORIZATION TO DISCONTINUE DEDUCTION SECTION

I _____, Employee No._____ authorize my "employer to deduct the amount noted below from my wages and to transmit the deduction amount to the Massachusetts State Health Care Professionals' Dental Fund in order to pay for **HIGH Option** dental benefits for me and/or my dependent(s). These deductions are in addition to the Employer's contribution to the Fund on my behalf. This authorization shall be in effect for no less than one (1) year, unless you have a family status change.

☐ SINGLE **HIGH** OPTION PLAN **($10.25 FOR WEEKLY PAYROLL DEDUCTION) ($20.50 FOR BIWEEKLY PAYROLL DEDUCTION)**

☐ FAMILY **HIGH** OPTION PLAN **($25.75 FOR WEEKLY PAYROLL DEDUCTION) ($51.50 FOR BIWEEKLY PAYROLL DEDUCTION)**

☐ I AUTHORIZE MY EMPLOYER TO **DISCONTINUE THE EMPLOYEE DEDUCTION ASSOCIATED WITH THE HIGH OPTION PLAN**. I UNDERSTAND THAT THE DEDUCTION WILL BE DISCONTINUED AS SOON AS ADMINISTRATIVELY POSSIBLE AND I WILL BE RE-ENROLLED IN THE STANDARD PLAN OF BENEFITS AT NO COST TO ME.

PRINT NAME:	**SIGNATURE:**	**DATE SIGNED:** ____/____/_____

CHECK THE APPLICABLE BOX FOR THE EMPLOYER WHERE YOU WORK:

☐ COMMONWEALTH OF MASSACHUSETTS (2037346) FILL IN YOUR EMPLOYER NAME & PHONE #:_____ ( ) _____-_____

☐ UMASS MEDICAL SCHOOL (2037347) FILL IN YOUR EMPLOYER NAME & PHONE #:_____ ( ) _____-_____

☐ UMASS MEMORIAL HEALTHCARE (2037348) FILL IN YOUR EMPLOYER NAME & PHONE #:_____ ( ) _____-_____

☐ UMASS DARTMOUTH (2037349 / 2037351) FILL IN YOUR EMPLOYER NAME & PHONE #:_____ ( ) _____-_____

☐ UMASS MAINTENANCE (2037350) FILL IN YOUR EMPLOYER NAME & PHONE #:_____ ( ) _____-_____

Email, Mail or Fax Completed Enrollment Form To:

Massachusetts State Health Care Professionals' Dental Fund, Attn: Amalgamated Employee Benefits Administrators
333 Westchester Avenue, White Plains, NY 10604
Phone: (800) 338-4330 **Fax**:(914) 367-5793 **Email**: MassNurseEnrollments@amalgamatedbenefits.com **Website**: www.massnurses.org/dental-fund

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A STATEMENT CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME.