ALPHA
Dental Plan

Employee Enrollment Packet

Beta Health Association, Inc.

"Dental Plan Specialists since 1990"

970-683-5424 (Grand Junction)
719-545-3652 (Pueblo)
303-744-3007 or 1-800-807-0706 (Corporate Office)

www.betadental.com

Beta Health Association, Inc.

"Dental Plan Specialists Since 1990"

How to use this Alpha Dental Plan
Employee Enrollment Packet

1. **If you wish to enroll in the Alpha Dental Plan then:**

   - **Complete the enclosed "Alpha Dental Employee Enrollment Form" included with this packet.**
   - **Include all family members you want to enroll (if applicable).**
   - **Select a participating Alpha Dental office by placing the provider's office number (column #3 of directory) in the box marked "Dental Office Selected".**
   - **Sign and date your enrollment form.**
   - **Submit your enrollment form to Personnel for processing.**

2. **If you wish to waive all Dental coverage for the next year then:**

   - **Complete the Waiver section of the "Alpha Dental Employee Enrollment Form" included with this packet and submit to Personnel for processing.**

IMPORTANT REQUIREMENTS

All employees MUST either enroll in the Alpha Dental Plan or sign the waiver form. If you waive coverage, you can only enroll again at the next open enrollment period. If you enroll in the plan, you must be enrolled for a minimum of one year and may not drop the plan until the next open enrollment period. The only exception to this rule is if you terminate employment.

If you have any questions regarding these enrollment guidelines, please call us at 303-744-3007 or 1-800-807-0706.

Employee Enrollment / Waiver Form

Complete this form to enroll in the Alpha Dental Plan #19

SOCIAL SECURITY NUMBER | LAST NAME | FIRST NAME | DATE OF BIRTH | HOME PHONE #

HOME ADDRESS | CITY | STATE | ZIP CODE | WORK PHONE #

MALE / FEMALE | DENTAL OFFICE SELECTED | EFFECTIVE DATE | GROUP #

NAME AND ADDRESS OF EMPLOYER

I AUTHORIZE PAYROLL DEDUCTION AND AGREE TO REMAIN ON THE PLAN FOR A MINIMUM OF ONE YEAR UNLESS MY EMPLOYMENT TERMINATES.

EMPLOYEE SIGNATURE ______________________ DATE ______________________

LIST ALL ELIGIBLE DEPENDENTS BELOW WHO YOU WISH TO ENROLL

LAST NAME	FIRST NAME	SEX (M OR F)	BIRTHDATE
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Complete this form if you are waiving coverage until the next Open Enrollment period

I, ________________________________, have been provided the opportunity to participate in the Dental Plans being offered through my employer. It is my decision:

_____ NOT to cover spouse, children, and myself

_____ NOT to cover my spouse and children

I understand that if my employer is contributing towards this benefit, that I will not be entitled to receive any monies in lieu of non-participation. I further understand that I will not be eligible again until the next open enrollment.

WITNESSED: ____________________ SIGNED: ______________________ DATE: ________________

This form needs to be faxed to the Beta Health Association, Inc. Administrative office immediately after completion. Our fax number is 303-744-2890.