

# **EMPLOYERS REFERENCE GUIDE TO BILLING AND ENROLLMENT**



**Offered by:  
Maine Municipal  
Employees Health Trust**

*“The Difference is Trust.”*

"This is a guide to billing and enrollment provisions for employee benefits options offered by a participating employer with the Maine Municipal Employees Health Trust. The purpose of the guide is to offer assistance to employers administering the benefits selected by each employer. In the case of any inadvertent discrepancies, actual Plan Document provisions will govern."

Updated: May 2012

## HEALTH TRUST CONTACT LIST

### PROGRAM INFORMATION

**1-800-452-8786 (In Maine) or 207-623-8428**

Information about the Health Trust plan offerings, benefits presentations, or proposals.

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### BENEFIT QUESTIONS

**1-800-852-8300 (In Maine) or 207-621-2645**

Medical, Life, Dental or Disability claims submitted by Insured, Doctor, Dentist, Hospital or Medical Facility.

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### BILLING AND ENROLLMENT

**1-800-452-8786 (In Maine) or 207-623-8428**

Eligibility, enrollment, effective dates, monthly premiums, adjustments on monthly billing.

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### IDENTIFICATION CARDS & SUPPLIES

**1-800-452-8786 (In Maine) or 207-623-8428**

Status of identification cards, additional cards, supplies.

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### WELLNESS WORKS

**1-800-452-8786 (In Maine) or 207-623-8428**

Information on health education and promotion programs, classes, grants, etc.

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It is important to us that we give you the best service possible. Please be sure to make note of the name of the Health Trust Representative you speak with, in the event there are further questions.

**WEB SITES – [www.mmeht.org](http://www.mmeht.org) (Health Trust); [www.anthem.com](http://www.anthem.com); [www.anthemprescription.com](http://www.anthemprescription.com)**

**HEALTH TRUST FAX NUMBER: 207-624-0166**

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Appendix – Includes All Samples Referred to in “The Guide”

Samples:

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2	Salary Change Notification Form
3a	Sample Health Trust Bill – First Page
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19a	Request for conversion materials
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**Please note – if you need new forms, please go to the Health Trust Web site – [www.mmeht.org](http://www.mmeht.org)**

**Please do not use samples in place of actual forms.**

## **JOINING A HEALTH TRUST PROGRAM**

The Health Trust must receive a letter of intent from an employer that chooses to make any Health Trust program available to their employees. The letter must state the intended effective date for each plan in which the employer wishes to join and must be sent to the Health Trust with completed applications for coverage.

### **Check your personnel policy to see if:**

- A. All full time employees are eligible for this coverage and determine if eligibility is limited to a specific department or bargaining unit.
- B. Any part time employees who work a minimum of an average of 20 hours a week on a year round basis are eligible for this coverage. If not, how many hours must a part time employee work to be eligible for this coverage?
- C. Any elected and/or appointed officials are eligible to participate in this coverage.

### **Know your employer's waiting period (see page 3). Know which coverages your employer offers.**

Have enrollment forms ready for new employees, ensuring applications for all Plans offered by your employer are provided to each new employee. **(You should include applications and information for all programs in which your employer participates.)**

Employees must complete an application for **each Plan** in which he/she will be enrolling, checking to be sure that all information is correct. This includes social security numbers and dates of birth for the employee and all of his/her dependents to be covered.

### **ADDRESS ALL APPLICATIONS/FORMS REFERENCED IN THIS GUIDE TO:**

**MMEHT  
ATTN: BILLING DEPARTMENT  
60 COMMUNITY DRIVE  
AUGUSTA, MAINE 04330-9486**

After applications are received and processed, a packet will be issued to the employee. The packet will contain a "welcome letter" confirming each plan in which the employee is enrolled, effective dates of enrollment for each plan and dependent status for all signed applications received by the Health Trust. The packet will also contain inserts explaining COBRA rights, Mastectomy/Breast Reconstructive surgery rights and a Summary Plan Description booklet for each plan in which the employee has enrolled. The employer will receive a copy of the welcome letter for the employee's file (sample #1).

### **IDENTIFICATION CARDS: Cards take up to 2 weeks to be printed and will be sent directly to the participant.**

All medical plan cards for active employees and retirees not on Medicare are printed by Anthem and will serve as combined prescription and medical cards. The identification cards will have the Health Trust logo and the Anthem Blue Cross Blue Shield logo on the front.

Retirees on Medicare will also receive one card: Retiree Group Companion Plan Cards that are printed by Anthem Blue Cross Blue Shield and will serve as combined Group Companion Plan card and prescription drug card. The identification cards will have the Anthem Blue Cross Blue Shield and a prescription drug logo printed on the front.

## MEMBERSHIP

Employees are able to enroll in one of the following types of contracts:

Employee	coverage for employee only
Employee & Spouse	coverage for employee & spouse only (same premium as family coverage under Medical)
Employee and Child(ren)	coverage for employee and dependent child(ren) (same premium as family coverage under Dental)
Family	coverage for employee, spouse and dependent child(ren) (same premium as employee & spouse under Medical; same premium as family coverage under Dental)
+19 Dependents	may be carried on either employee and child(ren) or family contract if between the ages of 19-26. <b>There is no additional charge for these dependents, under either of these two coverage types.</b>

There are four enrollment periods when an employee may join the Health Trust Health Insurance Plan.

1. When the employee is first hired (see section on waiting periods - page 3)
2. Within 60 days of a qualifying event (see section on qualifying events - page 10)
3. During the annual open enrollment period (see section on annual open enrollment - page 10)
4. Within 60 days after loss of other coverage (see section on portability - page 29)

Coverage will be effective on the first day of the calendar month that coincides with or follows the end of the waiting period selected by the employer, provided we receive the application before the effective date. If application is not made within 60 days of a new employee's eligibility date, the applicant will be considered a late enrollee unless there is either a qualifying event or loss of other coverage (portability).

A retiree (as defined by the Plan; see page 24 for details) shall become covered for benefits as a retiree on the first day of the calendar month coincident with or next following his/her date of retirement, provided proper application for coverage and any required contributions are made.

If there is any discrepancy between this booklet and the Health Trust Plan Document, the Plan Document provisions shall apply.

### **WAITING PERIOD**

The waiting period is the length of time an employee must wait before he or she is eligible to enroll in the group plan offered by the Maine Municipal Employees Health Trust. The EMPLOYER establishes the waiting period when the group opts to participate in the program(s) offered, with the exception of the Long Term Disability (LTD) program, which has been set by Unum at three (3) months for all participating groups. Waiting periods are calculated from the first working day of the month.

The Health Trust must receive the employee's Application for Enrollment before the end of the waiting period for coverage to be effective on the earliest possible date. However, if we receive the application no more than 60 days after the end of the waiting period, coverage is effective on the first day of the calendar month after the application is received by the Health Trust. If an application is received after that, the applicant will be considered a late enrollee and must satisfy Evidence of Insurability for Life, IPP and LTD; and wait until the annual enrollment period in December for Health, Dental and Vision coverage.

### **WAIVER OF WAITING PERIOD**

An employer may waive any existing waiting period for an employee, with the exception of the waiting period for the Long Term Disability (LTD) plan, by sending a letter along with the application stating that it is the intent of the employer to waive the waiting period for all programs, or a specific program (see samples listed below). The LTD plan is offered by the Health Trust through Unum and has a fixed waiting period of three (3) months for all eligible employees. The waiting period for the LTD plan cannot be waived.

### **CHANGING YOUR GROUP'S WAITING PERIOD**

The Health Trust must be notified in writing of an Employer's desire to change an existing waiting period for any or all of the programs in which the employer participates.

### **SAMPLE WORDING TO WAIVE WAITING PERIOD**

- Enclosed please find an enrollment application for John Doe. Mr. Doe was originally hired by the Town of Utopia as a part-time employee (20 hours per week) on 01-02-11 and was not at that time eligible for benefits under the policy of the town. The town council has voted to make Mr. Doe a salaried employee and also offer him health insurance benefits effective 07-01-11. Please waive the normal 90-day waiting period and begin his coverage as of 07-01-11.
- Enclosed please find an enrollment application for John Doe. Mr. Doe is a new employee with the Town of Utopia and the town would like to have the waiting period required by the town waived and make his coverage effective 07-01-11.

## DEFINITION OF ELIGIBILITY

An individual must meet certain requirements in order to be eligible for coverage under the Health Trust plans. The Maine Municipal Employees Health Trust eligibility requirements are as stated below:

1. Employees who are hired on a full or part time basis and **work an average of 20 hours per week on a year round basis** are eligible for coverage. (The employer may impose a higher minimum if so desired.)
2. Elected officials, whose term is of at least one year's duration, regardless of the work schedule, may be eligible for coverage. (This is at the employer's discretion.)
3. Appointed officials, whose term is of at least one year's duration, provided they work an average of at least 20 hours per week, are eligible for coverage. (The employer may impose a higher minimum if so desired.)
4. For Dental, Income Protection Plan (IPP), Long Term Disability (LTD) and Life Plans, if the employee is not actively at work on the day coverage would become effective because of a non-job-related injury or illness, the coverage will become effective on the day he/she returns to work full time. However, Dental and Life coverage for any eligible dependents may begin as though the employee was actively at work, provided the dependents are not disabled at such time. Health insurance coverage will begin on the employee's effective date if he/she is actively at work, available to work if it is not a regularly scheduled work day, or absent from work due to a non-work related illness or injury.
5. If the employee is not actively at work on the day the coverage would become effective because of a job-related injury or illness, coverage for all other disabilities or illnesses will become effective on the normal effective date.

## DEPENDENTS

Eligible dependents will be covered on the same date as the employee, provided application has been made for them within 60 days of the Employee's eligibility date. The **only** persons considered eligible dependents are:

1. The legally married spouse of an employee. (Effective January 1, 2000, Domestic Partners may be covered if the employer authorizes such coverage. Please call the Health Trust for more information.)
2. Children who are between the ages of birth and 26 years, including natural children, adopted children, stepchildren and other children under the legal guardianship of the employee.
3. Newborn care is provided for dependents of covered dependent children (i.e., grandchildren), but only for the first 31 days from the date of birth; a newborn dependent of a covered dependent child is not eligible for continued coverage beyond 31 days from the date of birth
4. An unmarried covered dependent child who is incapable of self-sustaining employment by reason of mental retardation or physical handicap, and who is chiefly dependent upon the employee for support and maintenance, provided proof of such incapacity and dependency is furnished to the Plan by the covered person within 31 days of the child's 26<sup>th</sup> birthday. The Health Trust may require, at reasonable intervals during the two years following the dependent's 19<sup>th</sup> (or 26<sup>th</sup>) birthday, subsequent proof of the child's continued disability and dependency. After such two-year period, the Health Trust may require subsequent proof not more than once each year.

## EXCLUDED AS DEPENDENTS

The Health Trust does **not** allow employees to cover any of the following as eligible dependents:

1. A spouse **legally** separated or divorced from the employee.
2. Any person(s) while on active duty in any military service of any country.
3. A married couple working for the same employer cannot be covered as both an insured and a dependent of the other. Any dependent children may be covered by one parent only.
4. Live in companions. (Note: Domestic Partners may be covered, if the employer authorizes such coverage. Please call the Health Trust for more information.)

## EVIDENCE OF INSURABILITY

When an application for the Life, Income Protection Plan, or Long Term Disability plan is not received by the Health Trust within 60 days from the date of hire, within the waiting period or within 60 days following the end of the employer's waiting period, the applicant is considered a late enrollee and must satisfy Evidence of Insurability.

The Health Trust will mail an Evidence of Insurability form directly to the employee to complete and return to the Health Trust. Upon receipt of the completed form, it will be logged in by the Health Trust and sent to the applicable Underwriting Department for immediate review. The employee will be notified if any additional information is needed to process the application. The applicant will be notified as soon as possible after a decision has been made.

If a late enrollee is applying for **Long Term Disability coverage** or **Income Protection Plan coverage**, or for an increase in the Income Protection Plan benefit, he/she must complete the questionnaire answering all questions with regard to him/her only, being sure to complete the sections asking for date of birth, height and weight.

Late enrollees (employees that did not enroll when originally eligible) will be able to enroll in the **Dental plan** during the annual enrollment period in the month of December for a January 01 effective date and will be subject to late entrant provisions. This means a late enrollee will need to be on the plan for defined periods of time before certain services are covered. This provision replaces the individual underwriting and Evidence of insurability process.

If a late enrollee is applying for **Life insurance coverage**, a personal health statement must be completed and returned to the Health Trust. However, if the life enrollment is received during either the Health Trust's annual Open Enrollment period for health insurance, or as part of an employer's cafeteria plan open enrollment, this requirement is waived and the application for Basic Life insurance and/or one unit of Supplemental Life insurance for the employee will be accepted without evidence of good health. **The application must be received in conjunction with a health enrollment application.** If the late enrollee includes a dependent child on his/her application, Evidence of Good Health is not required for the child.

NOTE: When the Health Trust does not receive an application for **Health insurance or Vision insurance** within 60 days of the date of hire or within 60 days following the end of the waiting period, the applicant will be considered a late enrollee. He/she must wait until the Plan's annual enrollment period in December to enroll, unless there is a qualifying event or portability applies. Please refer to page 10 (annual open enrollment and qualifying events) and to page 29 (portability) for further information.

## SALARY CHANGES

It is **imperative** that salary changes be reported to the Health Trust **as soon as they occur**. Salaries affect life insurance as well as Income Protection Plan and Long Term Disability plan benefits.

The Salary Change Notification Form must be completed to change salaries (sample #2). The following information is necessary:

- a) Complete the Employee ID# as it appears on the Health Trust bill..
- b) Name of the employee as it appears on the Health Trust bill.
- c) Actual **ANNUAL** salary; not rounded.
- d) Indicate if the employee was actively working on the date of the salary change.

**Do not wait to send the salary changes with the bills when you send payment, as this may delay the effective date of the change.**

The salary should be reported as an exact annual salary, and should not be rounded up or down. Salaries are based on a normal work week and do not include overtime unless it is part of an employee's normal work week (for example, if it is in the employee's contract).

Salary changes are effective **the next billing cycle** following receipt by the Health Trust. For example, on August 10<sup>th</sup> September bills are run. Salary changes received on August 11<sup>th</sup> will be effective October 1<sup>st</sup>. This holds true even if the employee's raise is retroactive (for example, in the case of a bargaining unit contract ratified retroactively), the salary change (for purposes of the Health Trust plans) is not.

Prompt reporting will prevent an employee from receiving an incorrect benefit if he/she files a disability claim.

Prompt reporting will also ensure that a beneficiary receives the correct benefit amount in the event of the employee's death.

**Salary change forms are now available on the Trust's website!**  
**[www.mmeht.org](http://www.mmeht.org)**

## RECONCILING THE MONTHLY BILLING

**It is the responsibility of the employer to review each monthly bill to ensure that all individuals have correct coverage.**

Bills are mailed the middle of the month for coverage in the upcoming month. For example, April's bill is mailed in mid-March. Payment is due on the first of each month; please pay your bill promptly. If payment has not been received, a "Late Notice" will be sent to the employer on approximately the twentieth day of the month in which the bill was due. If no payment is received after this notice, payment on claims for all employees (and their dependents) will be suspended until premium payments have been received.

An example of a Health Trust bill is included as sample #3 (a-b).

Check your bill carefully. If there are any questions about your billing, please do not hesitate to call the Billing and Enrollment department at 1-800-452-8786, ext. 2261/2262.

Check to see that all eligible employees are covered.

Status codes listed in the "health/dental/vision status" columns are: D1 = Employee-only coverage, D3 = Employee and Spouse coverage, D4 = Employee and Child(ren) coverage, D5 = Family coverage.

Employees need to be deleted from your billing effective the first day of the calendar month following their last day actively worked. (Note: This does not include employees who are absent from work and collecting benefits from Worker's Compensation or IPP)

If an employee retires and is to remain on the employer's billing, deduct the billed premium for all coverages. Note on the Termination Notification Form (sample #4) to bill the employer, and the date the employee retired. In order for coverage to continue, the employee / retiree must complete and return the Health Plan Application for Continued Enrollment as a Retiree to the Health Trust. Once the Health Trust receives this completed form, the retiree will be added back to the bill. Coverage will be reinstated retroactive to the date of the employee's retirement. There will be no lapse in coverage, and arrears will be billed as necessary.

For an employee who has terminated his/her employment for any reason, highlight his/her name and premium(s) billed. Deduct the premium(s) from the total premium due, complete a Termination Notification Form (sample #4) and attach it to your bill when you remit payment to the Trust.

If an employee requests cancellation for any coverage, highlight the premium for that coverage and deduct that amount from your payment. Do this even if the employee only wants to cancel coverage under one Plan and keep the rest. Complete a Termination Notification Form (sample #4), note "C" for cancellation requested and check boxes of coverage(s) to be cancelled. Send the Termination Notification Form to the Trust along with your payment.

If an application for enrollment has been submitted for an employee and the employee's name does not appear on the billing, **DO NOT** add the employee to the billing. Adjustments will appear on the next bill and will reflect a double billing if necessary.

If an Application for Change has been submitted for an employee and the change is not reflected on the billing, **DO NOT** adjust the premium. All credits or arrears will appear on the next month's bill.

It is **VERY IMPORTANT** that you complete the final page of the billing (sample #3b). This is **federally required information** and must be completed **EVERY** month. The employee's share is the total dollar amount that is deducted from **all** employees for **each program**. The employer's share is the total dollar amount that is paid by the employer for each program.

Each employer will receive two copies of the monthly billing. Please reconcile your monthly bill and return one copy, along with your check and termination forms, as soon as possible. This will avoid confusion and enable us to notify terminated employees of their options for continuation of coverage through the Health Trust. **Bills and payments received by the 10<sup>th</sup> of the month will ensure that maintenance is updated prior to the next billing.** Refunds of excess premiums paid in error will be limited to three (3) months. Mail premium payments to:

**MMEHT  
ATTN: FINANCE DEPARTMENT  
60 COMMUNITY DRIVE  
AUGUSTA, MAINE 04330-9486**

## **HOW TO ENROLL**

The employer must complete the employer section of all applications, stating your full employer name as it appears on your HealthTrust monthly bill. Fill in the department code number if applicable (sample #5), the annual salary, the date of hire and the number of hours the Employee is scheduled to work each week. If an employee is applying for health insurance coverage, indicate which medical plan the employee has chosen, making sure that this is an option offered by the employer.

**The Health program and the Basic Life program go hand in hand.** The employee must complete the Health Application for Enrollment/Change (sample #6), along with a Life Plan Employee Enrollment Form (sample #7) designating his/her desired beneficiary. Completing and returning these forms as soon as possible assures the employee of coverage, provided all eligibility requirements have been met.

An employee who has health insurance through another source should be offered basic life insurance with the Health Trust. Life-only coverage is available at a nominal fee. To enroll in the life coverage only, the employee must complete a Life Enrollment form (sample #7). Please be sure to fill in the employee's annual salary. Check the "Life-No Medical" box located under Type of Coverage.

A part-time employee who is not eligible for benefits (as stated in the employer's personnel policy and as stipulated in the Health Trust guidelines) may, if his or her hours are increased or if he/she becomes full time, apply for benefits using the date of the increase in hours or full time employment as the "date of hire" (see sample wording on page 3).

**If an employee is enrolling in a Point of Service (POS) Medical Plan or in the PPO 500 or 1000 (Providers of Distinction) plan, a primary care physician must be listed for the employee as well as for each of his/her dependents to be covered. Failure to list a Primary Care Physician will delay the production of an identification card and claims processing.**

**To enroll in Supplemental or Dependent Life insurance coverage**, if this option is available to employees; complete an MMEHT Life Plan Employee Enrollment Form (sample #7) and check the appropriate coverage boxes in the middle of the form. Employees must be enrolled in Basic Life coverage to be eligible for Supplemental or Dependent Life coverage.

**To enroll in the Income Protection Plan (IPP) program**, if this option is available to employees; complete an Income Protection Plan Application for Enrollment (sample #8). The employee may choose to be covered at 40%, 55%, or 70% of his/her annual base salary. The top portion of the application must be fully completed by the **employer**, including the annual salary and the number of hours the employee works each week. The employer must also indicate if the employee is actively working as of the effective date of coverage, or available to work if it is not a regularly scheduled work day. The bottom of the application must be fully completed by the **employee**.

**To enroll in the Long Term Disability program**, if this option is available to employees, complete the appropriate Long Term Disability Insurance Enrollment Form (sample #9a and sample #9b). There are two different applications: one for coverage with employer-paid premiums, and one for coverage with employee-paid premiums. The application must include the employee's exact annual salary.

**To enroll in the Dental program**, if this option is available to employees; complete a Dental Plan Application for Enrollment/Change (sample #10).

**To enroll in the Vision (VSP) Plan**, if this option is available to employees; complete a VSP Vision Plan Application for Enrollment/Change. (sample 11).

By not returning the Life, Long Term Disability or Income Protection Plan enrollment forms in a timely manner, the employee risks the process of Evidence of Insurability and possible rejection or a delay of up to a month before coverage becomes effective. If the Health, Dental or Vision enrollment form are not returned in a timely manner, the employee may have to wait until the Health Trust's annual Enrollment period in December, in order to enroll. All applications must be returned within 60 days of the date of hire, or, if a waiting period is required by the employer, within 60 days of the date of the end of the waiting period.

**Do not add a new employee to your billing. This will be done automatically when the applications are received. Any adjustments will be made on the following month's bill.**

## QUALIFYING EVENTS

At any time during the course of the year, if a qualifying event occurs, the employee and his/her eligible dependents may join the health, dental or vision plan without being considered late enrollees. Dependents may not enroll in the Health Trust health, dental or vision plan unless the employee is enrolled.

Qualifying events are as follows:

- a. Marriage.
- b. Birth of a child.
- c. Adoption of a child.
- d. Placement of a child for adoption within an employee's home.

The Health Trust must receive proof of the event along with the original application to enroll within 60 days of the qualifying event.

## ANNUAL OPEN ENROLLMENT PERIOD

Once each year, during the month of December, an Annual Open Enrollment period is allowed for anyone who did not enroll in the **Health, Dental or Vision** plan when he/she was originally eligible. No Evidence of Insurability is required for enrollment in Health, Dental or Vision insurance. In addition, employees enrolling in the Health insurance plan during Open Enrollment period may also enroll in Basic Life insurance and one unit of Supplemental Life insurance (provided that coverage is available to employees) without having to provide Evidence of Insurability.

If an application is completed and received by the Health Trust between December 1 and December 31, health, dental and vision insurance coverage for the employee and his/her eligible dependents will be effective January 1 of the following year. Late Entry Provisions will apply to those enrolling in **Dental** insurance through the Open Enrollment Period.

**The Health Trust must receive the Health, Dental or Vision application forms no later than December 31<sup>st</sup>.**

**Please note: The Health Trust annual open enrollment period applies only to the Health, Dental and Vision insurance,** (and to Basic Life and one unit of Supplemental life, if applied for in conjunction with the Health insurance). It does **not** apply IPP, or LTD coverage.

## ELECTION NOT TO ENROLL

In the event that a new hire declines health insurance coverage under the Health Trust, please have him/her fill out the Group Medical Plan Election for Enrollment/Change form, signing and dating the **Election Not to Enroll** section at the bottom of the form. (sample #6). This section notes the circumstances under which an employee could enroll, should coverage with the Health Trust become desirable. This form is **NOT** used to cancel existing coverage. (Refer to page 23, Termination.)

## **FLEXIBLE CHOICE OPTIONS**

Any employer who offers the Flexible Choice Option has an Annual Election period for all eligible participating employees to be effective January 1<sup>st</sup> each year.

All eligible employees are given the opportunity to choose to participate in the health option of their choice, if the employer offers a Flexible Choice Option.

Eligible employees who wish to make a change in coverage plan (POS or PPO) must complete the Health Application for Enrollment/Change Form (sample #6) and list eligible dependents to be covered on their plan. The Primary Care Physician must be listed for each covered member if changing to a Point of Service plan or to the PPO 500 or 1000 (Providers of Distinction) plan.

The Health Trust must receive the completed Health Application for Enrollment/Change Form (sample #6) no later than the date stated in the annual letter mailed to the employees, for an effective date of January 1st.

Please mail applications to the Health Trust only for employees who choose to change their medical plan.

For any employee who chooses to remain with the plan in which he/she is currently participating, file the completed application in the employee's personnel folder.

## CHANGES IN STATUS AND ADDRESS

A Health /Dental/Vision Application for Enrollment/Change form (sample #6, #10, #11) must be completed for any of the reasons listed below. These changes will be reflected in the health, dental, and vision policies only, except as otherwise noted. **No changes can or will be made to an employee's contract without his/her signature.**

- a) Change of name (Only one form required to change records for all programs)
- b) Change of address (Only one form required to change records for all programs)
- c) Marriage (see page 14)
- d) Newborn and Adopted Children – legal documentation is needed for adoption (see page 15)
- e) Divorce/Legal separation (see page 16)
- f) Legal Guardianship (submit a copy of legal documents – page 15)
- g) Death of a covered dependent (note date of death)
- h) Enter military service (see page 28)
- i) Obtain Medicaid or State assistance
- j) Loss of other insurance (certificate of coverage from former insurer will be required, including reason for loss of other coverage)
- k) Acquire other insurance (include company name and effective date of coverage)
- l) Other (any reason not listed with an explanation)

To add or drop a dependent from an employee's Health, Dental or Vision coverage, complete a Health, Dental, and/or vision Application for Enrollment/Change form (sample #6, #10, #11) listing the dependent's name, reason code, date of the event and checking the appropriate coverage box(es).

When adding a dependent, make sure all information is complete and accurate. If the employee is enrolled in the Point of Service program or PPO 500 or 1000 plan, be sure to include the name of the Primary Care Physician for the new dependent(s).

Providing the appropriate reason code on the change form will help determine the effective date of the change whether an addition or a drop.

The Health Trust is responsible for administering COBRA (Consolidated Omnibus Budget Reconciliation Act) unless the employer elects to administer COBRA themselves. COBRA is a federally required continuation of group health, dental and vision coverage, so this information is extremely important. The reason code indicated on the change form will help the Health Trust to determine the termination date of coverage as well as the length of COBRA coverage offered for dropped dependents.

Social security numbers are very important for all applications and dependents.

Mail all change applications to the Health Trust Billing Department as soon as they are completed.

**NO CHANGE CAN BE MADE TO THE EMPLOYEE'S CONTRACT WITHOUT THE EMPLOYEE'S SIGNATURE.**

### DEPENDENTS AGE 19 - 26

When a covered dependent reaches the age of 19, that dependent is eligible for continued coverage under the insured's contract at no additional charge (other than the regular dependent premium) if he/she is:

- Under the age of 26 and/or,
- Mentally or physically disabled and incapable of self-support. The disability must have begun before the child's 19<sup>th</sup> (or 26<sup>th</sup>) birthday and the child must have been covered under the insured's contract on that birthday.

A dependent over the age of 19 who is not a qualified dependent is no longer eligible for coverage under the employee's contract and must be dropped from the policy. COBRA will be offered to the dependent for a period of up to 36 months if he/she chooses to accept the coverage at his/her own expense.

**Approximately two (2) months prior to the dependent's 26<sup>th</sup> birthday**, the employee will be notified that, as of the first of the month following the dependent's 26<sup>th</sup> birthday, that dependent will be terminated from the policy and COBRA will be offered, unless the insured has provided proof of incapacity, showing that the dependent cannot support him/herself due to a mental health or physical medical condition. In such cases, the employer will be notified as the change in dependent status may affect the premium billed.

## MARRIAGE

When an employee marries, he/she may add his/her spouse and any dependent children (see section on Definition of Eligibility, page 4) to his/her Health, Dental, or Vision Plan provided the employee applies within 60 days of the date of marriage. In addition, an employee who is not currently enrolled in the Health, Dental or Vision Plan may enroll (either alone or with dependents) in the Health, Dental or Vision Plan, within 60 days of his/her marriage. **A separate application is needed to enroll in each Plan.**

To add a spouse and/or dependent children to an employee's existing Health, Dental, or Vision Plan, the employee must complete a Group (Health, Dental, Vision) Application for Enrollment/Change form (samples #6, 10, 11). To enroll him or herself, either with or without dependents, the employee must complete a Health Application for Enrollment/Change (sample #6), a Life Plan Employee Enrollment form (sample #7) where applicable, a Dental Application for Enrollment/Change (sample #10) and/or a Vision Enrollment/Change form (sample #11).

The effective date of coverage for the newly-married employee, his/her spouse and/or dependents, will be the first day of the calendar month following receipt of the application by the Health Trust, provided it is received within the 60-day eligibility period.

If the application is received after the 60-day eligibility period, the newly-married employee (if not previously enrolled), his/her spouse and any dependent children will be considered late enrollees and must wait for the annual open enrollment period to be enrolled in the Health, Dental or Vision insurance program.

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## NEWBORNS AND ADOPTED CHILDREN

Newborn children are automatically covered under the employee's Health insurance for 31 days from the date of birth. However, the Health Trust must be notified of the birth and application must be made to the Health Trust, in order for any claims to be paid.

The Health Trust must receive a Group Application for Enrollment/Change form (sample #6) within 60 days of the date of birth, and if all required contributions (if any) are paid, coverage will be continuous from birth. Premiums will be billed retroactively to the first of the month following the date of birth.

To add an adopted child or a child under the employee's legal guardianship to an employee's Health coverage, a Group Health Application for Enrollment/Change (sample #6) must be completed and received by the Health Trust within 60 days from the date the employee becomes legally responsible for that child. Coverage will begin on the first date of legal responsibility. Premiums will be billed retroactively to the first of the month following the date of legal responsibility. **Be sure to include a copy of the legal documents to expedite processing of the application.** If the insured is enrolled in the Point of Service medical plan or the PPO 500 or 1000 plan, be sure to include the name of the child's Primary Care Physician.

If the Group Application for Enrollment/Change form is not received within the above stated time frames, the child will be considered a late enrollee and must wait for the annual open enrollment period to be covered under the health and vision plans.

To enroll a dependent child in the dental program, a Group Dental Application for Enrollment/Change form (sample #10) must be received by the Health Trust within 60 days of the child's second birthday. Premiums will be billed retroactively to the first of the month following the child's second birthday.

To add an adopted child or a child under the employee's legal guardianship to the dental programs, a Group Dental Application for Enrollment/Change form (sample #10) must be received by the Health Trust within 60 days of the date of adoption or legal guardianship or within 60 days of the child's second birthday, whichever comes later. **Be sure to include a copy of the legal documents to expedite processing of the application.**

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## DIVORCE

**The law states that until a final divorce judgment or decree of judicial separation is entered, each party is enjoined from voluntarily removing the other party or any child or children of the parties from any policy of health insurance that provided coverage for the other party or the child or children of the parties.**

In the event an employee divorces, the spouse is not considered to be an eligible dependent and must be removed from the employee's policy when the divorce becomes final; coverage ends the first of the month following the date of the divorce. Complete a Group Health Application for Enrollment/Change form (sample #6) to remove the spouse from the employee's Health contract and mail the form to the Health Trust.

To remove the spouse from the employee's Dental contract, the insured must complete a Dental Application for Enrollment/Change form (sample #10).

To remove the spouse from the employee's Vision contract, the insured must complete a Vision Enrollment/Change form (sample #11).

If an employee drops a spouse because of divorce or legal separation, the employee should review his/her Life insurance beneficiary. The employee must complete a Life Plan Employee Change form (sample #13) to change beneficiaries. Check the box marked "Beneficiary Change" at the top of the form.

The following information is necessary to enable the Health Trust to offer COBRA continuation of Health and/or Dental benefits to an ex-spouse following a divorce:

- The name of the ex-spouse and any child(ren) no longer to be covered by the employee.
- The current mailing address of the ex-spouse.
- The birth date and social security number of the ex-spouse.

Once the Health Trust receives the application(s), the change will be effective the first of the month following the date the divorce is final. A letter will be mailed to the ex-spouse and/or dependents that no longer qualify as dependents according to the guidelines set by the Health Trust, offering them continuation of benefits through COBRA.

If a spouse is dropped prior to a divorce or separation, and said spouse notifies the Health Trust that the divorce or separation is not legalized, the spouse will be added back to the employee's policy and the employer will be billed accordingly.

If a divorced spouse is not properly dropped from the policy, the Health Trust will not reimburse premiums in excess of 3 months, unless the ex-spouse accepts COBRA and pays the premiums.

## LEGAL SEPARATION

When an employee and his/her spouse obtain a legal separation from the presiding court, the employee must submit Health Application for Enrollment/Change form (sample #6) to remove the spouse and any dependent child(ren) no longer eligible from his/her Health policy.

To remove the spouse from the employee's Dental policy, the insured must complete a Dental Application for Enrollment/Change form (sample #10).

To remove the spouse from the employee's Vision policy, the insured must complete a Vision Application for Enrollment/Change form (sample #11).

Once the application(s) have been received by the Health Trust, the change will be effective the first of the month following receipt by the Health Trust. A letter will be mailed to the spouse and /or dependents that no longer qualify as dependents according to the guidelines set by the Health Trust, offering them continuation of benefits through COBRA.

**LIFE INSURANCE PLAN**

**Basic coverage** equal to one times an active employee’s annual salary (rounded to the next higher \$1,000; to a maximum of \$100,000) is provided to all employees participating in a Health Trust Medical Plan, at no additional cost to employee or employer, provided the Employee enrolls when first eligible or following a qualifying event, or during the annual Health open enrollment period (applications received during the annual open enrollment period must be accompanied by a health enrollment application). Eligible elected or appointed municipal officials receive a minimum benefit of \$5,000, and a maximum benefit of \$50,000. Any employee, who is eligible to participate in the Health Trust Medical Plan, but does not elect coverage because he/she is covered under another medical plan, may participate in the Basic Life Plan for a nominal premium amount. Benefits for active employees are reduced by 50% at age 70. When an employee reaches age 70, the Health Trust will notify him/her of the right to convert the reduced amount of coverage to an individual life insurance policy through Standard Insurance Company. The life plan provided by the Health Trust also includes Accidental Death and Dismemberment (AD&D) coverage, which means the benefit amount, is doubled if the covered person dies as the result of an accident.

**Accelerated Benefit** – The Health Trust’s life insurance carrier (Standard Insurance Company) will pay up to 75% of the employee’s Life benefit if they receive proof that the employee is terminally ill and are certified by a physician to have 12 months or less to live. Any benefit amount paid under the Accelerated Benefit will be paid to the covered employee either in a single lump sum.

**Supplemental Coverage** (including AD & D) is available on a contributory or non-contributory basis for all active employees, provided the employer elects to make the supplemental coverage available. Employees may select coverage equal to an additional one times their annual salary without having to submit Evidence of Insurability. Employees may choose additional coverage for two or three times their annual salary by submitting Evidence of Insurability. The maximum total supplemental life benefit is \$300,000. Benefits are reduced by 50% at age 70. When an employee reaches age 70, the Health Trust will notify him/her of the right to convert the reduced amount of coverage to an individual life insurance policy through Standard Insurance Company.

**Dependent Coverage** - Two options are available on a contributory or non-contributory basis for dependent coverage, provided the employer elects to make the dependent coverage available.

**OPTION A:**

Spouse..... 1/2 employee’s Basic Coverage amount  
((\$5,000 maximum)

Children ..... 1/2 employee’s Basic Coverage amount  
(6 mo.-19yrs) (\$5,000 maximum)  
(25 if full-time student)

**OPTION B:**

1/2 employee’s Basic Coverage amount  
((\$50,000 maximum)

1/2 employee’s Basic Coverage amount  
((\$5,000 maximum)

**Retirees or Surviving Spouses**, who continue with the MMEHT Medical plan, receive Basic Life coverage at a flat amount of \$2,000. Accidental Death & Dismemberment coverage for retirees and surviving spouses will terminate at age 70.

**Note:** The life insurance premium will be waived for the employee’s Basic and Supplemental Life insurance coverage if the employee is totally disabled for 180 days or more while covered; and the employee is age 60 or less when the disability begins. Please call the Health Trust for details.

## **CHANGES IN SUPPLEMENTAL & DEPENDENT LIFE COVERAGE**

**To Add Supplemental coverage:** Check the “Benefit Change” box at the top of the MMEHT Life Plan Employee Change Form (sample #13), and indicate the type of change where requested on the form. This coverage is subject to Evidence of Insurability. The effective date of coverage, if approved, will be the first of the month following the date of approval by the Standard Insurance Company underwriters. Note: If the employee is a new employee or if the employer is offering Supplemental Life coverage to employees for the first time, then simply use the Life Plan Employee Enrollment Form (sample #7).

**To Drop Supplemental coverage:** Check the “Benefit Change” box at the top of the MMEHT Life Plan Employee Change Form (sample #13), and indicate the type of change where requested on the form. The effective date of the cancellation will be the first of the month following receipt of the Life Form by the Health Trust.

**To Change Supplemental coverage:** Check the “Benefit Change” box at the top of the MMEHT Life Plan Employee Change Form (sample #13), and indicate the type of change where requested on the form. Any increase in Supplemental coverage is subject to Evidence of Insurability. The effective date of coverage, if approved, will be the first of the month following the date of approval by the Standard Insurance Company underwriters. The effective date of any decrease will be the first of the month following receipt of the Life form by the Health Trust.

**To Add Dependent coverage:** Check the “Benefit Change” box at the top of the MMEHT Life Plan Employee Change Form (sample #13), and indicate the type of change where requested on the form. Dependent coverage for a spouse is subject to Evidence of Insurability unless there has been a status change within the previous 60-day period (i.e., marriage, birth or adoption of a child). The effective date of coverage, if approved, will be the first of the month following the date of approval by the underwriters. No Evidence of Insurability is required for Dependent Life coverage for children. Note: If the employee is a new employee or if the employer is offering Dependent Life coverage for the first time, then simply use the Life Plan Employee Enrollment Form (sample #7).

**To Drop Dependent coverage:** Check the “Benefit Change” box at the top of the MMEHT Life Plan Employee Change Form (sample #13), and indicate the type of change where requested on the form. The effective date of the cancellation will be the first of the month following receipt of the Life form by the Health Trust.

**To Change Dependent coverage:** Check the “Benefit Change” box at the top of the MMEHT Life Plan Employee Change Form (sample #13), and indicate the type of change where requested on the form. An increase in dependent coverage is subject to Evidence of Insurability unless the increase is made as a result of the employee’s marriage. Application for the increase due to marriage must be made within 60 days of the date of marriage. The effective date of coverage, if approved, would be the first of the month following the date of approval by the Standard Insurance Company underwriters.

**To Change Beneficiary:** Check the “Beneficiary Change” box at the top of the MMEHT Life Plan Employee Change Form (sample #13), and list new beneficiaries where requested on the form.

**NO CHANGE CAN BE MADE TO AN EMPLOYEE’S CONTRACT WITHOUT THE EMPLOYEE’S SIGNATURE.**

## **INCOME PROTECTION PLAN (IPP) CHANGES**

**It is extremely important that employers update salaries (see page 6, salary changes) on a timely basis to ensure that correct benefits are paid in the event an employee needs to submit a claim. Salary Change Forms are available on the Health Trust's website (www.mmeht.org).**

### **CHANGES IN COVERAGE**

Any time an employee wishes to **decrease** IPP benefits, he/she must complete a new Income Protection Plan Application for Enrollment (sample #8). Check the level the employee wishes to change to and check the Increase/Decrease Coverage box in the Enrollment Reason section of the form. The change will become effective the first of the month following receipt by the Health Trust.

Any time an employee wishes to **increase** IPP benefits to a higher percentage, he/she must complete a new Income Protection Plan Application for Enrollment (sample #8). Check the level the employee wishes to change to and check the Increase/Decrease Coverage box in the Enrollment Reason section of the form. Increases in benefit levels are subject to Evidence of Insurability. Coverage will become effective the first of the calendar month following the date of approval by UNUM underwriters.

### **BENEFIT CHANGES**

Any benefit increase for an Employee not actively at work as the result of a disability (i.e., currently receiving benefits under the Health Trust's Income Protection Plan) on the effective date of a salary change will not affect benefits paid for that period of disability. The employee will not be eligible to receive the new benefit until he/she qualifies for a new disability period.

Any salary increase reported for an employee not actively at work will not be billed. The Health Trust will contact you and ask you to report the salary increase again when the employee returns to work.

### **LONG TERM DISABILITY PLAN CHANGES**

It is extremely important that employers update salaries (see page 6, Salary Changes) on a timely basis to ensure that correct benefits are paid in the event an employee needs to submit a claim.

**NO CHANGE CAN BE MADE TO AN EMPLOYEE'S CONTRACT WITHOUT THE EMPLOYEE'S SIGNATURE.**

### **WAIVER OF PREMIUM FOR INCOME PROTECTION PLAN**

During the first six (6) consecutive months that an employee is continuously and totally disabled, any required premium must be paid in order for the employee to remain enrolled in the Income Protection Plan (IPP).

If the employee is disabled for a period longer than six consecutive months, starting on the first day of the seventh month of disability, the Health Trust will waive any IPP premiums due until the employee returns to work on either a full-time or part-time basis.

The monthly bill will list the employee's ID number and name along with a credit for the applicable month at the end of the bill for any employee who has been disabled for more than six months.

It is the responsibility of the employer to notify the Health Trust's Billing Department when the employee has returned to work on either a full-time or part-time basis, so the credit can be discontinued.

### **WAIVER OF PREMIUM FOR LONG TERM DISABILITY**

Premiums must be paid for the Long Term Disability (LTD) plan, even while the employee is out on an Income Protection Plan (short term disability) claim. Premiums for the employee's Long Term Disability coverage will be waived as of the date the employee first begins collecting LTD benefits, and throughout the period of the LTD claim. Premium billing for the LTD coverage will resume once the employee returns to work on a full-time basis.

### **WAIVER OF PREMIUM FOR LIFE INSURANCE**

Premiums for all your life insurance under the Group Policy, except AD&D insurance, will be waived once you become Totally Disabled while insured under the Group Policy and are under the age of 60, and have completed the 180-day waiting period. Satisfactory Proof of Loss will be required by Standard Insurance Company. Premium payments must be continued until the later of: 1. The date you complete your Waiting period; and 2. The date Standard Insurance Co. approves your claim for Waiver of Premium.

### **DENTAL ENROLLMENT AND CHANGES**

For an employer to participate in the Dental Program offered by the Health Trust, 50% of all eligible employees (see Definition of Eligibility, page 4) must participate in the program. An eligible employee must work a minimum of 20 hours per week on a year round basis. (Note: the employer may set a higher minimum if so desired.)

When an employer first chooses to offer the Dental Plan, the Health Trust must receive a letter of intent including the requested effective date of coverage and completed employee applications.

To enroll in the Dental program, an employee must complete a Dental Plan Application for Enrollment/Change (sample #10) including all eligible dependents to be covered, and mail it to the Health Trust. Employees do **not** have to be enrolled in the Health insurance plan in order to be eligible to enroll in the Dental Plan.

Coverage will become effective the first of the month following receipt of the application by the Health Trust provided all eligibility requirements have been met.

### **CHANGES IN AN EMPLOYEE'S COVERAGE**

If an employee wishes to add or drop a dependent after his/her initial enrollment, complete the appropriate Enrollment/Change form listing the dependent's name, birthday and social security number and the reason why the dependent is being added to or cancelled from the policy. Any additions received after the eligibility period will be required to wait for the Annual Open Enrollment period in December, and Late Entry Provisions will apply.

**NO CHANGE CAN BE MADE TO AN EMPLOYEE'S CONTRACT WITHOUT THE EMPLOYEE'S SIGNATURE.**

### **VISION ENROLLMENT AND CHANGES**

An eligible employee must work a minimum of 20 hours per week on a year round basis. (Note: the employer may set a higher minimum if so desired.)

When an employer first chooses to offer the Vision Plan, the Health Trust must receive a letter of intent including the requested effective date of coverage and completed employee applications.

To enroll in the VSP Vision Plan, an employee must complete a VSP Vision Plan Application for Enrollment/Change (sample #11) including all eligible dependents to be covered, and mail it to the Health Trust. Employees do **not** have to be enrolled in the Health insurance plan in order to be eligible to enroll in the Vision Plan.

Coverage will become effective the first of the month following receipt of the application by the Health Trust provided all eligibility requirements have been met.

### **CHANGES IN AN EMPLOYEE'S COVERAGE**

If an employee wishes to add or drop a dependent after his/her initial enrollment, complete the appropriate Enrollment/Change form listing the dependent's name, birthday and social security number and the reason why the dependent is being added to or cancelled from the policy. Any additions received after the eligibility period will be required to wait for the Annual Open Enrollment period in December.

**NO CHANGE CAN BE MADE TO AN EMPLOYEE'S CONTRACT WITHOUT THE EMPLOYEE'S SIGNATURE.**

## TERMINATION OR CANCELLATION REQUESTS

When an employee terminates employment for any reason, his/her Health, Life, Dental and Vision coverage end the first of the month following the last day the employee actually works, or the first of the month following the request for cancellation. Coverage under both the Income Protection Plan and Long Term Disability plans end at midnight on the last day that the employee is actively at work (i.e., coverage is terminated effective the day after the employee's employment terminates – these coverages do NOT continue until the end of the month).

On the monthly bill, the employer must highlight the coverage(s) to be cancelled, deduct the appropriate premiums from the payment and attach the Termination Notification Form (sample #4) to the bill prior to submitting it to the Health Trust. Be sure to note the employee's last day at work.

If an insured requests cancellation of one or more coverages, premiums for his/her coverage should be highlighted and deleted the first of the month following the date of the request. A Termination Notification Form (sample #4) should be attached to the bill with the code "C" for cancellation requested, boxes for coverage(s) to be cancelled should be checked.

For any employee who will no longer be covered for one or all benefit coverages, highlight the current month's premium(s) on your bill, for the coverage(s) involved. Deduct the current premium(s) from the total due **before** you submit your bill.

In the event your bill is paid prior to the due date and an unanticipated termination occurs after payment but within the month following the payment, please call Billing and Enrollment at 1-800-452-8786 **immediately** to receive proper credit.

Attach the completed Termination Notification Form (sample #4) to the bill when you deduct the payment. Complete the employer section only with name of the employee, current mailing address, employee ID #, last day actively at work and appropriate code, as follows:

### CODE:

- T Involuntary Termination
- V Voluntary Resignation
- L Temporary Layoff
- A Leave of Absence
- C Cancellation Requested
- D Death of the Employee (Note Date of Death)
- E Disability
- H Reduction of Hours making them ineligible for coverage
- M Retirement – Withdrawing from MPERS
- R Retirement – Not withdrawing from MPERS
- W Work Related Injury or Occupational Disease
- X Active Employee chooses Medicare & cancels Health Trust coverage
- F Military

In the event of an employee's (or dependent's) death, a certified copy of the death certificate must be sent to the Health Trust if the employee (or dependent) had life insurance coverage.

**Retroactive credits will not be given for more than three (3) months of back premiums. It is up to the group to reconcile their bill each month and make necessary adjustment(s) for any employee who has terminated employment.**

**Please note: If, as part of an employment severance package, an employer offers to pay health, dental and/or vision premiums for a period of time following the termination, the employee must be terminated as stated above. COBRA information will be sent to the employee, and the employer can pay premiums for the extended coverage under COBRA.**

## **FAMILY AND MEDICAL LEAVE (FMLA)**

The Family and Medical Leave Act (FMLA) requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to “eligible” employees for certain family and medical reasons. Employees are eligible if they have worked for a covered employer for at least one year, and for 1,250 hours over the previous 12 months, and if the employer employs at least 50 employees within a 75-mile radius.

### **Reasons for Taking Leave under FMLA**

Unpaid leave must be granted for any of the following reasons:

1. to care for the employee’s child after birth, or placement for adoption or foster care;
2. to care for the employee’s spouse, son or daughter, or parent, who has a serious health condition;
3. for a serious health condition that makes the employee unable to perform his/her job; or
4. to deal with “any qualifying exigency” that arises from a spouse’s, child’s or parent’s active duty in the armed forces, including an order or call to duty.

**Extended FMLA leave to care for injured service member.** Employees may take up to 26 weeks of leave to care for spouses, children, parents or next of kin with serious illnesses or injuries incurred during active duty in the armed forces. This leave is available in only one 12-month period and any other FMLA leaves in the same period count against the 26-week limit. As with all FMLA leaves, the time is unpaid, though employers may require employees (and employees may elect) to use any accrued paid time off.

At the employee’s or employer’s option certain types of paid leave may be substituted for unpaid leave.

### **Advance Notice and Medical Certification**

The employee may be required to provide advance leave notice and medical certification. Taking of leave may be denied if requirements are not met.

- ◆ The employee ordinarily must provide 30 days advance notice when the leave is “foreseeable.”
- ◆ An employer may require medical certification to support a request for leave because of a serious health condition and may require second or third opinions (at the employer’s expense) and a fitness for duty report to return to work.

### **Job Benefits and Protection**

- ◆ For the duration of the FMLA leave, the employer must maintain the employee’s health coverage under any “group medical plan.” The employer is not required to pay the employee’s insurance premiums, however, and may require the employee to contribute up to 100% of premium cost.
- ◆ Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.
- ◆ The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee’s leave.

### **Unlawful Acts by Employers**

FMLA makes it unlawful for any employer to:

- ◆ interfere with, restrain, or deny the exercise of any right provided under FMLA; or
- ◆ discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

### **Enforcement**

- ◆ The U.S. Department of Labor is authorized to investigate and resolve complaints of violations.
- ◆ An eligible employee may bring a civil action against an employer for violations.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

## RETIREMENT

When an employee retires from active employment, there are two ways he/she may qualify as a retiree and continue his/her health coverage through the Health Trust.

To qualify as a retiree under the Health Trust, the former employee must:

1. Be receiving (or have received) retirement benefits, other than Social Security benefits, from his/her current employer's retirement plan, and the employer must be participating in the Maine Municipal Employees Health Trust on the date of retirement; or
2. If the employer has no sponsored retirement plan or the employee has waived his/her rights to participate in the employer sponsored retirement plan, the employee must have been employed by, or have been an elected or appointed official of, the participating employer for at least five (5) consecutive years immediately prior to retirement **and** be at least 55 years of age on the date of retirement.

In both of the above cases, with the exception of a new group transferring into the plan, the "retiree" must have been an active participant in the Maine Municipal Employees Health Trust immediately prior to his/her retirement.

The employer should take the following steps regarding retirees when reconciling their Health Trust billing:

1. Highlight the retiring employee's name and any premiums to be cancelled.
  2. Deduct the premiums before making your payment.
  3. Complete a Termination Notification Form (sample #4), listing the employee's name, current mailing address, last day worked and the appropriate code, as listed below:
- Code M - Retiring and withdrawing from MPERS
  - Code R - Retiring and has not withdrawing from MPERS

When you notify the Health Trust that an employee is retiring by deducting his/her premium and coding the termination form, coverage for the employee and all of his/her dependents is temporarily cancelled. If the termination form is coded with an "R," fill out and return an "Employer Statement Regarding Retiree Eligibility for Continued Health Insurance" form (sample #14) and return it with your bill and Termination Notification Form so that the Health Trust can determine if the person retiring meets the qualifications of a retiree under the guidelines of the Health Trust. Once the person's eligibility is determined, the Health Trust will mail a letter and an informational packet to the retiree. Not all retirees choose to remain with the Health Trust so it is very important that any retiree who wishes to remain insured through the Health Trust complete the "Health Plan Application for Continued Enrollment as a Retiree" (sample #15). If the Retiree and/or spouse are over 65 and eligible for Medicare, he/she/they must also list their Medicare Claim Numbers and Effective Dates in the appropriate section of the form. The application must be returned to the Health Trust, along with a signed page 2 or page 3 of the letter, within 60 days of the date of the letter. At that time the retiree's coverage will be reinstated with no lapse in coverage. The retiree will be required to pay any premiums due during the interim period. All claims that are incurred during this interim period will be denied and it will be up to the insured to call and have the claims reprocessed once premium payments are made.

If the retiree is coded with an "M" and he/she wishes to have the monthly premium deducted from his/her Maine State Retirement System (MPERS) check, an "MPERS Deduction Authorization" (sample #16) will be included in the informational packet and must be completed and returned to the Health Trust. Once the completed application is received and processed by the Health Trust, the retiree will receive a bill from the Health Trust for any premiums due during this process.

## COVERAGE FOR RETIREES

When an individual reaches the age of 65, he/she is notified by Social Security if he/she is eligible for Medicare Parts A & B. If the employee or his/her spouse is actively working and has group health insurance, they do not need to sign up for Part B at this time. The employee should, however, notify Medicare that he/she is not enrolling in Part B, because he/she is still actively working.

- Part A - is automatic and is free of cost.
- Part B - has a monthly cost that will be automatically deducted from an individual's Social Security check.

When a covered employee retires, the Health Trust will mail a letter and an informational packet explaining the employee's options. If he/she wishes to continue health coverage through the Health Trust, the enrollment form, and page 2 or page 3 of the retirement letter, must be completed and returned within 60 days of the date of the letter. If the employee is 65 years old or older, he/she needs to complete the section of the application listing his/her claim number along with the effective dates of Medicare Part A & Part B.

In addition, if a retired employee becomes eligible for Medicare as the result of a disability, he/she should contact the Health Trust in order to be enrolled in the appropriate health insurance plan.

If an employee retires prior to his/her 65<sup>th</sup> birthday, the Health Trust will send an informational packet approximately two months prior to the individual's 65<sup>th</sup> birthday. This packet will contain an application that must be completed with the Medicare claim number and the effective dates of Medicare Part A & Part B from the employee's Medicare card.

If an employee works past his/her 65<sup>th</sup> birthday and later retires, he/she needs to notify Social Security approximately three months prior to retirement and sign up for Medicare Part B. Failure to do so may result in the individual being penalized by Social Security.

Retiree coverage can be confusing. We will try to simplify things for you here. **1. If a retiree is under age 65** and not eligible for Medicare, he/she will remain on the same coverage he/she had with the Health Trust prior to retirement, until the retiree reaches age 65 and/or becomes eligible for Medicare benefits. **2. If a retiree is age 65 or older and is eligible for Medicare upon retirement**, he/she must enroll in both Medicare Parts A and B and the Health Trust Group Companion Plan. In order for a retiree to have Companion Plan coverage the retiree must have Medicare Part A and Part B. The Health Trust will send the Group Companion Plan Application directly to the retiree. The retiree will have received a notice in the mail from Social Security three months prior to his/her 65<sup>th</sup> birthday to enroll in Medicare. **3. If a retiree is age 65 or older, but is not eligible for Medicare**, he/she will be able to remain on the same coverage he/she had in force prior to age 65. However, the retiree must indicate on the application included in the retiree packet that he/she is not eligible for Medicare, attach a copy of a statement of ineligibility from Social Security and return it to the Health Trust.

The retiree who is "Medicare eligible" and has enrolled in both Medicare Parts A & B will have the following coverage:

- Medicare Parts A & B - as the primary coverage.
- Health Trust Retiree Group Companion Plan - coordinates with Medicare as a supplement.
- The Health Trust prescription drug card.

**Prescription Drugs:** The retiree will retain the same prescription drug coverage as he/she had as an active employee.

**Dental and Vision Coverage:** If a retiree was participating in the dental and/or vision program(s) at the time of his/her retirement, he/she may continue the dental and/or vision coverage under COBRA for up to 18 months. If COBRA is accepted for the dental coverage, all claims should be submitted under the retiree's social security number, changing the first digit to an "8".

## **SPLIT COVERAGES FOR RETIREES**

When an employee retires with his/her spouse covered under the health insurance contract, and one person is eligible for Medicare and one person is ineligible for any reason, the employee and spouse are set up as a “split contract” for billing purposes.

The retiree and spouse will be provided with separate identification numbers.

In the event of a split contract, the individual with Medicare coverage will receive a Group Companion Plan card and prescription card in one from Anthem Blue Cross Blue Shield.

The individual without the Medicare coverage will receive a medical card from Anthem Blue Cross Blue Shield in his/her name.

All claims and any prescriptions filled should be processed under the number on the individual’s card.

When both the retiree and his/her spouse are eligible for Medicare, they will both be set up under one identification number. At this time they will receive two Group Companion Plan/perscription cards from Anthem Blue Cross Blue Shield in the retiree’s name, one for the retiree and one for his/her spouse.

## **LAYOFF OR LEAVE OF ABSENCE**

If an employee is absent from active work due to disability caused by a non-job-related injury or illness, coverage may continue until it is terminated by the employer according to the employer's written policy.

If an employee is temporarily laid-off or on a non-medical leave of absence, coverage may continue until it is terminated by the employer according to the employer's written policy, or the end of the third month after the month in which the layoff or leave of absence began, whichever comes first. (Note: Under the Long Term Disability plan, coverage may only continue until the end of the month following the month in which the layoff or leave of absence began.)

If coverage was terminated during a layoff or leave of absence, an employee may enroll in any or all plans being offered by the employer upon his/her return to work, noting the date that he/she returned to work as the date of hire. Coverage will become effective the first of the month following receipt of the application by the Health Trust, provided the application is made within 60 days of the date of return to work. The employer's waiting period will apply unless the Health Trust receives a written request from the employer to waive the waiting period (see page 3).

By not completing and returning the necessary applications in a timely manner, an employee risks the process of Evidence of Insurability for Life, Long Term Disability and Income Protection Plan coverage; and having to wait until the December annual open enrollment period for Health, Dental and Vision coverage.

## MILITARY DUTY

When an employee receives Activation Orders, the Health Trust must be notified by using the Termination Notification Form (sample #4).

Coverage will be continued to the end of the month in which the employee enters temporary military service.

Under USERRA (the federal Uniformed Services Employment and Reemployment Rights Act), the employee and his/her family members (if applicable) will be offered COBRA continuation of coverage for up to 24 months. The premium charged for the first 31 days will be the same amount he/she would have paid as an active employee. After that, the premium will be billed at 102% of the active employee premium.

If the employee and/or family members accept the COBRA option, the Health Trust will be secondary to any other coverages the employee may have (including Federal military medical programs, such as TriCare). The Health Trust will not provide benefits for expenses incurred while an individual is on full-time active duty in the armed forces of a country.

If the employee has dependents, they should also sign up for TriCare (formerly CHAMPUS) health insurance coverage offered by the military service. This is available to the employee at no cost. If TriCare coverage is selected for dependents, the Health Trust will be primary coverage and the TriCare benefits for dependents will be secondary.

If the employee has **Health** insurance coverage, as stated above, he/she has the choice of COBRA or TriCare while on active military duty. Once the employee returns from military duty and returns to active employment, his/her Health insurance coverage will be reinstated effective the first day he/she returns to work following military service.

If the employee has **Dental** coverage, COBRA continuation coverage will be offered. The military service does not provide any Dental coverage. Once the employee returns from military duty and returns to active employment, his/her Dental coverage will be reinstated effective the first day he/she returns to work following military service.

Coverage for **Life** Insurance can continue for up to 3 months after activation. After the 3-month period, the employee will have 31 days in which to convert to an individual policy. Dependent Life Insurance can be continued for up to 60 days after the employee is released from active duty. Life insurance coverage will be reinstated effective the first day the employee returns to work following active military duty.

The employee's **Income Protection Plan** and **Long Term Disability plan** coverage stop on the last day of work and will be reinstated effective the first day the employee returns to full-time employment following active military duty.

Following discharge from military service and upon the employee's return to work, he/she must complete applications for all programs that he/she had prior to termination, noting the date that he/she was discharged from the military and the date he/she returned to work. Coverage will become effective on the first day the employee returns to work after military service. Please include a copy of the employee's DD214 as proof of active military duty.

If the employee is reinstated by the employer on or before the 15<sup>th</sup> of the month, the Health Trust will charge a full month's premium; if the employee is reinstated after the 15<sup>th</sup> of the month, the Health Trust will not charge a premium for the remainder of that month.

**Please contact the Health Trust if you have any questions regarding the Health Trust's Extended Military Leave Policy.**

## PORTABILITY

The employee, his/her spouse, or any eligible dependents may choose not to enroll in the Health, Dental or Vision programs offered by the Health Trust because they are covered elsewhere. If the other health, dental and/or vision coverage end for any of the following reasons, the employee (and his/her eligible dependents) may still enter the Health, Dental and/or Vision programs offered through the Health Trust.

- a) Loss of the other insurance coverage due to termination of employment, or a reduction in the number of hours worked. The application to join the Health Trust must be accompanied by a certificate of coverage (if immediately available) from the former insurance company, showing start date, end date and full name of each person covered (sample #17). Application for coverage should be sent to the Health Trust as soon as possible after learning of the loss of other coverage. This will allow the Health Trust to apply the appropriate coverage effective date. However, the Trust will hold the processing of the application until the Certificate of Coverage is received.
- b) Loss of other coverage because such other coverage is no longer available.
- c) A change in the percentage of premium contribution required by the other plan (a copy of the intended change must be sent with the application).
- d) Divorce or legal separation.
- e) Death of the spouse.
- f) Loss of Medicaid benefits (a copy of the letter from the Department of Human Services must be provided).

## EXCLUDED UNDER PORTABILITY

- ◆ Voluntary cancellation for any reason other than listed above.

If an employee and/or dependent(s) meets the requirements of portability, he/she must complete a Group Medical Plan Enrollment/Change form (sample #6), a Life Insurance Enrollment form (sample #7) where applicable, a Dental Enrollment/Change form (sample #10), and/or a Vision Enrollment/Change form (sample #11), listing all eligible dependents to be covered. **The Health Trust must receive the application within 60 days of the date of the event.** Coverage will be made effective the first of the month following the later of the date of loss of other coverage, or receipt of the application by the Health Trust.

By not completing and returning the necessary applications in a timely manner, the employee risks the process of Evidence of Insurability for Life Coverage; and having to wait until the December annual enrollment period for Health, Dental and Vision coverage.

## COBRA

Federal law requires that most employer sponsored group medical plans offer employees and their dependents a temporary extension of health coverage at the employee's expense in instances when coverage would otherwise end. This coverage, which is mandated under the Consolidated Omnibus Budget Reconciliation Act, is known as COBRA. COBRA coverage is continued at group rates plus a small charge for administrative costs.

When an employee is no longer eligible for health, dental and/or vision coverage, COBRA continuation of coverage will be offered to the employee and his/her dependents that are covered at the time eligibility changes. The employer should terminate the employee from the monthly billing, cross out the employee's name, deduct the premium and attach a "Termination Notification Form" (sample #4) to the bill, noting the last day actively worked, the reason for the termination and the employee's current mailing address.

A letter, along with a "Subscriber Election Form To Continue Group Coverage" (sample #18), a "Certification of Health Coverage" (sample #17) and a "Notice of Conversion Privilege" (sample #19) to convert life coverage, will be mailed to the employee within 14 days following receipt of the notification to the Health Trust accompanying the monthly billing.

A copy of page 2 of the letter to the employee will be mailed to the employer for their personnel records (sample #20).

The employee's coverage will be terminated on a "pending basis" until COBRA is accepted.

If COBRA is accepted, the employee's coverage must be reinstated back to the date of the loss of group coverage. The employee will be issued a coupon booklet to use for making his/her monthly premium payments, once the first month's premium is received.

Payments are due on the first day of each month. To avoid cancellation, it is necessary to make payments in a timely manner. No benefits, including prescription drugs, will be processed beyond the "paid through" date.

COBRA may be accepted for the employee and/or all eligible dependents that were covered at the time of the loss of group coverage (or any one or more eligible dependents of the employee).

If COBRA is offered for health, dental and vision coverage, the employee and/or his/her eligible dependents may choose to accept any or all coverage plans offered.

Coverage may be continued for up to 18 months for employees, spouses, and dependents in case of loss of coverage as a result of the employee's:

- Termination of employment.
- Reduction in work hours (less than 20 hours per week).
- Layoff.

Coverage may be continued for up to 36 months for:

- Legally separated or divorced spouses and children of current employees.
- Children of current employees who no longer meet the Health Trust's definition of a dependent.
- Spouses and children of current employees who would lose coverage due to the employee are becoming entitled to Medicare benefits.

Note: Please see the section entitled Military Duty (page 28) for special continuation provisions for employees on active military duty, and their family members.

Coverage may be extended from 18 to 29 months for an individual who is disabled at the time of termination of employment, or who is disabled at the time of a reduction in hours of employment, or who becomes disabled within the first 60 days of COBRA coverage, provided the employee has provided notice of the disability to the Health Trust within 60 days of receiving such notice from Social Security, and before the end of the first 18 months of coverage.

COBRA is not available to anyone who becomes eligible for Medicare or other group coverage after he/she becomes effective on COBRA (unless that other group coverage contains a pre-existing condition limitation which would apply to that individual). Participants covered by Medicare on the date that active coverage terminates may also elect COBRA coverage. COBRA will be secondary to Medicare in this case.

In addition, it is important to note that COBRA continuation coverage is not available to Domestic Partners of covered employees. However, the Health Trust does offer a COBRA-like coverage, similar in many respects to COBRA, in the event that coverage for a Domestic Partner is terminated. Please contact the Health Trust for further details.

## **TERMINATION OF COBRA COVERAGE**

The Health Trust may terminate coverage prior to the expiration of the 18 or 36 month COBRA period under the following circumstances:

- The group/bargaining unit no longer provides health/dental/vision insurance to any of its employees.
- The group/bargaining unit no longer offers the Health Trust health/dental/vision insurance to any of its employees.
- The Health Trust does not receive premium payments in a timely manner.
- The participant becomes a covered employee under another group medical plan, unless that other group plan contains a pre-existing condition limitation that would apply to the participant. In this case, the employee will need to send a written cancellation notice to the Health Trust to end COBRA coverage.
- The participant remarries and becomes covered under another group medical plan, unless that other group plan contains a pre-existing condition limitation that would apply to the participant.
- The participant becomes entitled to benefits under Medicare subsequent to the COBRA effective date.

## **LIFE INSURANCE CONVERSION**

When an employee loses his/her Life Insurance coverage due to termination of employment or retirement, he/she is given the opportunity for conversion or portability of his/her Life Insurance to a personal policy through the Health Trust Life Insurance carrier at his/her own expense. The employee is eligible to apply for coverage lesser than or equal to the current coverage he/she has through the Health Trust, as well as any dependent coverage. Premiums are based on the employee's age and the amount of coverage that is chosen.

The Health Trust will mail a Notice of Conversion Privilege for Life Insurance and Application for Portability (sample #19) to the employee upon receipt of notification of the termination or cancellation of the employee's life coverage. It will be up to the employee to complete the form and mail it to the Health Trust's life insurance carrier (currently Standard Life Insurance Company) if he/she is interested in continuing this coverage. The carrier will notify the employee of the premium and give him/her the opportunity to accept the converted policy.

Standard must receive the application for conversion within 31 days following the participant's termination of group coverage or, if later, 15 days after his/her notification of conversion rights. Otherwise, he/she will be asked to provide Evidence of Insurability. In no event will the carrier allow for conversion extended beyond 91 days.

To receive an approximate quote on conversion or portability of life insurance, please call The Standard at 1-800-378-4668 ext. 6785.

CHECK LIST OF ITEMS TO GIVE NEW EMPLOYEES

**Town of Anywhere**

All new **eligible** employees should be given the following:

Informational material to assist them in choosing which program(s) they wish to enroll in.

Depending on the plans offered by the employer ...applicable enrollment forms:

Health POS C (Eligible employees must complete the health enrollment form or check off and sign the election not to enroll section)

Basic Life

Supplemental Life

Dependent Life

Dental

Vision

Income Protection Plan (IPP)

Long Term Disability

**If for any reason an eligible employee chooses not to enroll in any of the programs offered by the employer, they must sign the form(s) indicating they have been given the option and elect not to enroll.**

NOTE: ALL EMPLOYEES ELIGIBLE FOR HEALTH INSURANCE ARE ELIGIBLE FOR **BASIC LIFE INSURANCE**. If the employee **elects to enroll** in the health insurance, the **basic life insurance is included at no additional premium**. If the employee **elects not to enroll** in the health insurance, **HE/SHE MUST STILL BE OFFERED THE BASIC LIFE**. The basic life insurance is available to them for a nominal charge.

**Town of Anywhere has no waiting period for Health coverage offered through the Health Trust, as well as for the Income Protection coverage. Newly eligible employees must sign up for benefits within 60 days of hire date.**

# Income Protection Plan Information for Employers

## Employer Contact with Unum:

- A Unum Customer Care Representative may need to speak directly with the employer if additional information is required. For example, Unum may need to ask the employer if the employee has returned to work, to explore light duty job functions as recommended by the physician, or to explore ways the employee's job function can be temporarily modified so the employee can return to work.

## Claim Filing Procedures:

- If the employer pays any portion of the IPP premium, or if the employee pays his/her IPP premium on a pre-tax basis, a copy of the employee's current W-4 form must be included with the claim form.
- Please send your portion of the completed claim form directly to Unum to the address or fax number on the claim form.
- The employer should notify Unum when the disabled employee returns to work by calling 1-800-628-6096 or by faxing a notice to 1-800-793-1610.

## Tax Withholding and Reporting:

**(Please note: This section applies only to those employers who pay any portion of the premium for the IPP coverage, or who allow employees to pay their IPP premiums on a pre-tax basis)**

- Unum will withhold all employee and employer taxes (Social Security and Medicare taxes), if applicable. Unum will submit the taxes directly to the IRS on behalf of the Trust and the employer using the Unum Employer Identification Number (EIN). **Social Security and Medicare taxes will be withheld if the employer pays any portion of the employee's premium, or if the employee pays his/her premium on a pre-tax basis.**
- The Health Trust will bill the employer on a monthly basis for any applicable Employer share of taxes paid by Unum with Health Trust funds.
- Unum will generate a W-2 for the employee in January for all taxes withheld in the previous calendar year, and will mail the W-2 directly to the employee to file with his/her federal and state tax returns. As a result, you will be relieved of the administrative burden of tracking and reporting taxes that have been withheld from Income Protection Plan benefits.
- The maximum period of responsibility for payment of Social Security and Medicare taxes is six months per period of disability. After six months of disability payments (i.e., during one consecutive period of disability), the employer is no longer responsible for payment of Social Security or Medicare taxes.
- An employer will continue to be responsible for payment of Social Security and Medicare taxes, **even if the employee has terminated employment**, as long as the employee continues to receive payments under the Health Trust IPP benefit. Such taxes must be paid for a maximum of six months per period of disability.

If you have questions regarding any of these items, please contact a Health Trust Service Representative at 1-800-852-8300 or a Unum Customer Care Representative at 1-800-858-6843.

## **POTENTIAL TAX IMPLICATIONS OF PROVIDING DOMESTIC PARTNER BENEFITS**

There are certain potential tax implications to both the employee and the employer, of which all parties should be aware before domestic partner benefits are offered. Most of these implications are discussed in Section 152 of the Internal Revenue Code. Some of the major points shall be summarized here.

Internal Revenue Code Section 152(a) defines a "dependent" for federal tax purposes. This definition generally requires a blood relationship (including adoption) or a marital relationship, as well as a support test. In most situations, a domestic partner will not meet the Code requirements for the definition of a "dependent". In fact, a domestic partner will only meet the Code definition of a "dependent" if all of the following requirements are met:

1. the taxpayer (in this case, the employee) provides over 50% of the domestic partner's support;
2. the domestic partner's principal place of abode is that of the taxpayer/employee, and the domestic partner is a member of the taxpayer/employee's "household"; and
3. the relationship of the taxpayer/employee and the domestic partner does not violate state or local law. Under the Internal Revenue Code Section 152 (b)(5), if the relationship violates state or local law, the domestic partner cannot be considered to be a member of the employee's household, and therefore cannot be considered to be a dependent.

If a domestic partner does not meet the above requirements, and therefore does not meet the IRS requirements to be considered a tax-qualified dependent, then any domestic partner benefits provided by the employer will be considered taxable benefits to the employee. If the employer pays any portion of the premium (for health and/or dental insurance) for the domestic partner's coverage, the amount which the employer pays for that coverage is includible in the employee's income under Internal Revenue Code Section 61. So, for example, if the employer pays 50% of the cost of dependent coverage for an employee's domestic partner, that amount paid by the employer must be included in the employee's income.

In addition, any such amounts includible in the employee's income due to coverage of a domestic partner constitute wages under Section 3401(a) of the Internal Revenue Code, and are subject to income tax withholding, as well as FICA and FUTA taxes. This means that any employer that provides domestic partner benefits must put in place a procedural arrangement to ensure that W-2 tax forms are prepared for those employees who elect domestic partner coverage. These W-2 tax forms must include the value of the imputed income arising out of the domestic partner benefits. The employer must also be sure to make the necessary withholding and payroll tax payments.

Another issue which must be addressed by employers offering domestic partner coverage concerns payment of premiums by employees under a cafeteria plan or other pre-tax arrangement. If the employee pays all or any portion of the cost for domestic partner coverage, that portion of the premium must be paid on an after-tax basis, unless the domestic partner meets the dependent definition in Code Section 152. In a Private Letter Ruling issued by the IRS in 1995 (IRS Private Letter Ruling 9603011, October 18, 1995), the IRS ruled that, if a domestic partner is neither a spouse nor dependent (as defined earlier in this memo), then:

1. premiums paid by the employer for domestic partner coverage must be included in the employee's income, as already described; and
2. the employee cannot pay any part of the premium for the domestic partner's coverage on a pre-tax basis. Thus, even if the employer has a plan in place for employees to pay their portion of health and/or dental insurance premiums on a pre-tax basis, employees would not be able to pay for domestic partner premiums pre-tax. Any contribution which the employee makes toward the cost of coverage for his/her domestic partner must be made on an after-tax basis.

Because of all the potential tax implications and complications arising from the offering of domestic partner coverage, the Health Trust strongly recommends that any employer group offering such coverage consult with its payroll administrator, tax consultant and/or attorney, and (if applicable) cafeteria plan administrator.

THIS DISCLOSURE IS NOT INTENDED TO CONSTITUTE TAX ADVICE, BUT RATHER IS INTENDED TO HIGHLIGHT SOME OF THE COMPLEX TAX AND ADMINISTRATIVE ISSUES ARISING OUT OF DOMESTIC PARTNER BENEFIT COVERAGE. EMPLOYERS ARE ENCOURAGED TO CONSULT THEIR OWN ACCOUNTANTS FOR SPECIFIC TAX ADVICE.

Date: November 2011

To: Health Trust Employers - Please forward a copy to your Finance/Payroll Department  
From: Sarah D. Ledoux, Controller  
Re: Life Insurance Tax Information

In 1996, the Health Trust received a "private letter ruling" from the IRS in regard to the taxable aspects of the Basic and Supplemental Life Insurance plans. This ruling was requested by the Health Trust and two of its members. Technically, the ruling applies to these two members only, but the information is the same for all Trust members.

The ruling essentially states that the purchase of Supplemental Life insurance by an employee will result in no taxable income, irrespective of the amount, because the Basic Life and Supplemental Life plans offered by the Trust are two separate plans.

Listed below is a summary of the year-end tax reporting requirements for employers who provide life insurance to their employees:

- A. **Employees (including retirees): The cost of any employer-paid group term life insurance in excess of \$50,000 must be reported as part of an employee's income. (This includes the life coverage under the Health Plan and any other employer-paid life insurance coverage.) The calculation of taxable amount is explained below along with the IRS Rate Table.**
- B. **Dependents:** The cost of an employer-paid group term dependent life insurance of \$2,000 or less is not includible in the employee's income. If the amount provided is more than \$2,000, the cost of the coverage is includible in the employee's taxable income based on Table 1.
- C. **Tax Withholding & Reporting:** To the extent that the cost of group term life insurance is included in an employee's taxable income both Social Security and Medicare FICA taxes must be withheld. Includible amounts are not subject to federal or state income tax withholding, but must be reported on Form W-2. (consult with your payroll service or software provider to see if this calculation can be done as part of your regular payroll processing!)
- D. Table 1 below is published by the IRS and gives you uniform premiums for \$1,000 of group term life insurance. The "age" refers to the employee's age on the last day of the taxable year.

To compute the cost of excess coverage:

- (1) Total the life coverage in force for each month of the year. From this total, deduct \$50,000 for the same number of months (up to \$600,000). This is the "Life Excess" for consideration of possible taxable income;
- (2) Determine the employee's age at year-end and apply the appropriate rate to the "Life Excess" computed in Step 1;
- (3) Determine the employee's contributions for the year, only if contributions are made as an after tax deduction. If contribution is before taxes, no credit is allowed.
- (4) If the amount in Step 3 is more than the amount in Step 2, there is NO taxable income. If the amount in Step 3 is less than the amount in Step 2, then the difference represents the amount to be added to the W-2 taxable income.
- (5) The amount should included in all boxes related to taxable income on the W-2, such as in Boxes 1, 3, 5, 16 and also entered in box 12 with code C.

<b>2011</b>	
<b>Table 1</b>	
Cost per \$1,000	
Age	eff 7/1/99
under 25	0.05
25 to 29	0.06
30 to 34	0.08
35 to 39	0.09
40 to 44	0.10
45 to 49	0.15
50 to 54	0.23
55 to 59	0.43
60 to 64	0.66
65 to 69	1.27
70 and above	2.06

**EXAMPLES OF CALCULATIONS ARE SHOWN ON THE BACK SIDE OF THIS PAGE**

If you should have any questions, please don't hesitate to call me at 1-800-452-8786

Addendum 3 10-10-11

MMEHT Letter re: Life Insurance Tax Information

	JANUARY TO JUNE	JULY TO DECEMBER	
<b>EXAMPLE ONE</b> <b>NO EMPLOYEE CONTRIBUTION TO HEALTH COVERAGE</b>			
Employee Age at End-Of-Year	52		
Enter amount of life coverage included in Health Premium	\$60,000	\$62,500	
Less: \$50,000 per month	50,000	50,000	
Excess amount of insurance	\$10,000	\$12,500	
Number of months at this coverage	6	6	
Total coverage in excess of \$50,000 for the year	60,000	75,000	135,000
Divide this amount by \$1,000			135.00
Multiply by cost per \$1,000 per Table 1			0.23
Cost of excess life insurance for entire tax year - Total Included in Income			\$31.05

THIS AMOUNT IS LISTED ON EACH OF THE HEALTH TRUST'S MONTHLY BILLINGS

	JANUARY TO JUNE	JULY TO DECEMBER	
<b>EXAMPLE TWO</b> <b>EMPLOYEE CONTRIBUTES PERCENTAGE TO HEALTH COVERAGE</b>			
Employee Age at End-Of-Year	52		
Base: Coverage (included with Health Premium)	\$60,000	\$62,500	
percentage employee pays for Single Coverage	10%	10%	
amount of insurance paid by employee	\$6,000	\$6,250	
Coverage Provided By Employer	\$54,000	\$56,250	
Less: \$50,000 per month	50,000	50,000	
Excess amount of insurance	\$4,000	\$6,250	
Number of months at this coverage	6	6	
Cost of excess life insurance for entire tax year	24,000	37,500	61,500
Divide this amount by \$1,000			61.50
Multiply by cost per \$1,000 per Table 1			0.23
Total Included in Income			\$14.15

	JANUARY TO JUNE	JULY TO DECEMBER	
<b>HEALTH CONTRIBUTION IS AN "AFTER TAX" DEDUCTION</b>			
Employee Age at End-Of-Year	52		
Base: Coverage (included with Health Premium)	\$60,000	\$62,500	
percentage employee pays for Single Coverage	10%	10%	
amount of insurance paid by employee	\$6,000	\$6,250	
Coverage Provided By Employer	\$54,000	\$56,250	
Less: \$50,000 per month	50,000	50,000	
Excess amount of insurance	\$4,000	\$6,250	
Number of months at this coverage	6	6	
Cost of excess life insurance for entire tax year	24,000	37,500	61,500
Divide this amount by \$1,000			61.50
Multiply by cost per \$1,000 per Table 1			0.23
Total Included in Income			\$14.15

	JANUARY TO JUNE	JULY TO DECEMBER	
<b>EXAMPLE THREE</b> <b>EMPLOYEE CONTRIBUTES FIXED AMOUNT TO HEALTH COVERAGE</b>			
Employee Age at End-Of-Year	52		
Enter amount of life coverage included in Health Premium	\$60,000	\$62,500	
Less: \$50,000 per month	50,000	50,000	
Excess amount of insurance	\$10,000	\$12,500	
Number of months at this coverage	6	6	
Total coverage in excess of \$50,000 for the year	60,000	75,000	135,000
Divide this amount by \$1,000			135.00
Multiply by cost per \$1,000 per Table 1			0.23
Cost of excess life insurance for entire tax year			\$31.05
Less: Amount paid by employee toward Single Coverage	Amount	# of Paydays	
	\$5.00	26	130.00
Total Included in Income (if contribution exceeds cost of excess amount = 0)			\$0.00

	JANUARY TO JUNE	JULY TO DECEMBER	
<b>HEALTH CONTRIBUTION IS A "BEFORE TAX" DEDUCTION</b>			
Employee Age at End-Of-Year	52		
Base: Coverage (included with Health Premium)	\$60,000	\$62,500	
percentage employee pays for Single Coverage	10%	10%	
amount of insurance paid by employee	\$6,000	\$6,250	
Coverage Provided By Employer	\$54,000	\$56,250	
Less: \$50,000 per month	50,000	50,000	
Excess amount of insurance	\$4,000	\$6,250	
Number of months at this coverage	6	6	
Cost of excess life insurance for entire tax year	24,000	37,500	61,500
Divide this amount by \$1,000			61.50
Multiply by cost per \$1,000 per Table 1			0.23
Total Included in Income			\$31.05

	JANUARY TO JUNE	JULY TO DECEMBER	
<b>EXAMPLE ONE</b> <b>NO EMPLOYEE CONTRIBUTION TO DEPENDENT COVERAGE</b>			
Dependent Age at End-Of-Year	63		
Enter amount of life coverage included in Health Premium	\$50,000	\$50,000	
Less: \$2,000 per month	2,000	2,000	
Excess amount of insurance	\$48,000	\$48,000	
Number of months at this coverage	6	6	
Total coverage in excess of \$2,000 for the year	288,000	288,000	576,000
Divide this amount by \$1,000			576.00
Multiply by cost per \$1,000 per Table 1			0.66
Cost of excess life insurance for entire tax year - Total Included in Income			\$386.16

	JANUARY TO JUNE	JULY TO DECEMBER	
<b>HEALTH CONTRIBUTION IS A "BEFORE TAX" DEDUCTION</b>			
Dependent Age at End-Of-Year	63		
Enter amount of life coverage included in Health Premium	\$50,000	\$50,000	
Less: \$2,000 per month	2,000	2,000	
Excess amount of insurance	\$48,000	\$48,000	
Number of months at this coverage	6	6	
Total coverage in excess of \$2,000 for the year	288,000	288,000	576,000
Divide this amount by \$1,000			576.00
Multiply by cost per \$1,000 per Table 1			0.66
Cost of excess life insurance for entire tax year - Total Included in Income			\$386.16

**EMPLOYER pays full cost of \$3.20 per mth**  
**Annual Cost** \$38.40  
**\$137.14**



Maine Municipal  
 Employees Health Trust  
 60 COMMUNITY DRIVE  
 AUGUSTA, MAINE 04330-9486  
 (207) 621-2645

# Sample #1

TO: Ben E. Fitz  
 25 Municipal Lane  
 Anywhere, ME 04000

FROM: Maine Municipal Employees Health Trust  
 Billing and Enrollment Department

DATE: May 4, 2012

<b>ID #:</b>	A000123456					
<b>EMPLOYER:</b>	Town of Trustville					
<b>PLAN:</b>	<b>Health:</b>	POS C	<b>Status:</b>	Family	<b>Effective:</b>	June 1, 2012
	<b>Dental:</b>	Dental	<b>Status:</b>	Family	<b>Effective:</b>	June 1, 2012
<b>Dental Late Entry Provision:</b>	NO	If YES, then waiting periods apply for the first year: Preventive – none, Basic/Restorative – 6 months, Major/Prosthodontics – 12 months.				
<b>IPP PERCENTAGE:</b>	70%	<b>Effective:</b>	June 1, 2012			
<b>VISION:</b>		<b>Effective:</b>				
<b>LTD:</b>		<b>Effective:</b>				
<b>BASIC LIFE:</b>	\$27,000	<b>Effective:</b>	June 1, 2012			
<b>LIFE-NO MEDICAL:</b>		<b>Effective:</b>				
<b>SUPPLEMENTAL LIFE:</b>	\$27,000	<b>Effective:</b>	June 1, 2012			
<b>DEPENDENT LIFE:</b>		<b>Effective:</b>				

Welcome to the Maine Municipal Employees Health Trust!

Under Federal Law, the Health Trust is required to inform you, as a new participant, of your rights under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) regarding health, vision, and dental insurance. The enclosed material will explain your rights under the COBRA law, should your coverage with the Maine Municipal Employees Health Trust terminate.

The Health Trust is also required by Federal Law to notify all new participants of benefits available for mastectomies and reconstructive breast surgeries. Please read the enclosed notice.

Included in this packet is a Summary Plan Description benefit booklet for coverage(s) listed above. If you have questions regarding benefit coverage, please call a Health Trust Service Representative at 1-800-852-8300 or 207-621-2645.

Please read this information carefully. If you have any questions pertaining to the effective date or level of coverage, please call the Health Trust Billing and Enrollment Department at 1-800-452-8786.

Enclosure



**Maine Municipal  
Employees Health Trust**

60 COMMUNITY DRIVE  
AUGUSTA, MAINE 04330-9486  
(207) 621-2645  
www.mmeht.org

# Sample #2

**NOTIFICATION OF SALARY CHANGE**

Month of July 2012

All salary changes **must** be reported to the Health Trust to update coverages for Life Insurance and/or Income Protection. All changes will be effective with the next month's billing following **receipt** of notification.

Please list below all employees who have had salary changes:

<u>EMPLOYEE ID#</u>	<u>EMPLOYEE NAME</u>	<u>ANNUAL SALARY</u>	<u>EFFECTIVE DATE</u>	<u>IS EMPLOYEE ACTIVELY WORKING AS OF EFFECTIVE DATE?*</u>
<u>A0001234</u>	<u>Ben E. Fitz</u>	<u>\$27,852.61</u>	<u>07/01/12</u>	<u>YES</u>
<u>A00056789</u>	<u>Cal Q. Later</u>	<u>\$42,325.50</u>	<u>07/01/12</u>	<u>NO</u>
<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>
<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>
<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>
<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>
<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>
<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>
<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>
<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>
<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>
<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>
<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>

Health Trust Employer: \_\_\_\_\_  
Office/Title: \_\_\_\_\_ Date: \_\_\_\_\_

\* Benefits for any employee not actively at work on the effective date will be effective the first of the month following return to work.

# Sample #3a

Trustville, Town of  
123 Down Street  
Pleasantville, ME 04000

Page 1

SUBGROUP ID	GROUP ID	INSURANCE MONTH	STATEMENT DATE
MHT 11111	MHT	July 2011	July 10, 2011

**LEGEND**  
C - CHANGE  
N - NEW INSURED  
T - TERMINATED INSURED  
P - PRIOR PREMIUM DUE  
R - REFUND OF PREMIUM

INSURED NAME	INSURED ID	LEGE	LTD PREM	IPP PREM	IPP BNFT	LIFE VOLUME	LIFE NO MED PREM	SUPP LIFE VOLUME	SUPP LIFE PREMIUM	DEPLIFE PREM	VISION PREMIUM	V STAT	DENTAL PREM	D STAT	HEALTH PREM	H STAT	TOTAL PREMIUM
Anderson, Jack	000-00-0000					22,000							19.32	D1	219.13	D1	238.45
Bermer, Leon	000-00-0000	C		19.55		19,000					63.65	D5	491.51	D5		D5	574.71
Chandler, Mark	000-00-0000			34.05		33,000					63.65	D5	357.54	D4		D4	455.24
Daniels, Chad	000-00-0000			18.17		22,000					19.32	D1	219.12	D1		D1	256.61
Fitz, Benny	000-00-0000	T															
French, Alan	000-00-0000					2,000									223.60	D1	223.60
Jackson, Helen	000-00-0000					23,000					63.65	D5	491.51	D5	491.51	D5	555.16
Johnson, Nancy	000-00-0000	N				26,000					63.65	D5	491.51	D5		D5	555.16
Katz, Sandra	000-00-0000					42,000	14.70										14.70
Kinnaman, Joan	000-00-0000					54,000					63.65	D5	491.51	D5	491.51	D5	555.16
Lyons, Barbara	000-00-0000			16.49													16.49
McLean, Jean	000-00-0000			12.67		21,000					33.35	D3	491.51	D3		D3	537.53
Richards, Joseph	000-00-0000			24.85		30,000					63.65	D5	491.51	D5	491.51	D5	560.01
Rozers, Kathy	000-00-0000			23.91		29,000					19.32	D1	223.60	D1		D1	266.83
Stone, Timothy	000-00-0000					28,000					63.65	D5	491.51	D5	491.51	D5	555.16
Tarr, Gary	000-00-0000					23,000							491.51	D5	491.51	D5	491.51
Taylor, Edward	000-00-0000					22,000					19.32	D1	219.13	D1		D1	238.45
Wagner, Heidi	000-00-0000			26.21													26.21
Wilson, Matthew	000-00-0000			18.57		23,000					63.65	D5	491.51	D5	491.51	D5	573.73
Young, Carol	000-00-0000			17.30													17.30
<b>Current Month Premium</b>			<b>0.00</b>	<b>211.77</b>		<b>419,000</b>	<b>14.70</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>			<b>619.83</b>		<b>5,885.71</b>		<b>6732.01</b>
<b>***ADJUSTMENTS***</b>																	
Jackson, Helen	000-00-0000					26,000							63.65		491.51		555.16
Jul 2011		P															0.00
Fitz, Ben E	000-00-0000												19.32		491.51		523.50
Jul 2011		R		-12.67		21,000											-12.67
Wagner, Heidi	000-00-0000																0.00
Jul 2011		R		-26.21													-26.21
<b>Total Adjustments</b>			<b>0.00</b>	<b>-38.88</b>		<b>5,000</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>			<b>44.33</b>		<b>0.00</b>	<b>0.00</b>	<b>5.45</b>
<b>EMPLOYEES: 18</b>	<b>TOTALS</b>		<b>0.00</b>	<b>172.89</b>		<b>424,000</b>	<b>14.70</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>			<b>664.16</b>		<b>5,885.71</b>	<b>0.00</b>	<b>6737.46</b>





Maine Municipal  
Employees Health Trust  
www.mmeht.org

# Sample #4

## TERMINATION NOTIFICATION FORM

Please list below all employees for whom you have DELETED PAYMENT on this month's billing, giving the reason for termination of coverage (see list), date of event and current address. Return this form to the Health Trust with your monthly bill when you remit your Premium.

List Date of Last ACTIVE Day of Work		EMPLOYER USE ONLY		FOR MMEHT USE ONLY			
		Employee's Name & Mailing Address		Dependents' Names		Start Dates	Life Vol.
<b>Code:</b>	<b>Date:</b>	<b>Employee</b>		<b>Employee End Date</b>			EE
		<b>ID#:</b>		<b>Dep 1</b>			SP
If term code is "C", check all boxes that apply.	Health	Life	<b>Address</b>	<b>Dep 2</b>			DEP
	IPF	Dental		<b>City/State</b>		<b>Dep 3</b>	
	Vision	LTD				<b>Dep 4</b>	
<b>Code:</b>	<b>Date:</b>	<b>Employee</b>		<b>Employee End Date</b>			EE
		<b>ID#:</b>		<b>Dep 1</b>			SP
If term code is "C", check all boxes that apply.	Health	Life	<b>Address</b>	<b>Dep 2</b>			DEP
	IPF	Dental		<b>City/State</b>		<b>Dep 3</b>	
	Vision	LTD				<b>Dep 4</b>	
<b>Code:</b>	<b>Date:</b>	<b>Employee</b>		<b>Employee End Date</b>			EE
		<b>ID#:</b>		<b>Dep 1</b>			SP
If term code is "C", check all boxes that apply.	Health	Life	<b>Address</b>	<b>Dep 2</b>			DEP
	IPF	Dental		<b>City/State</b>		<b>Dep 3</b>	
	Vision	LTD				<b>Dep 4</b>	

Reason for Coverage Termination:	
T Involuntary Termination	H Reduction of Hours making them ineligible for coverage
V Voluntary Resignation	M Retirement – Withdrawing from MPERS
L Temporary Layoff	R Retirement – Not withdrawing from MPERS
A Leave of Absence	W Work Related Injury or Occupational Disease
C Cancellation Requested	X Active Employee chooses Medicare & cancels HT
D Death of the Employee - Note Date of Death	F Military
E Disability	

Municipality/Employer Name

Signature of Person Completing

04/26/12

DEPARTMENT CODES BY NUMBER

10 EMERGENCY MGMT AGCY  
 11 CORRECTONS  
 12 DISPATCH  
 13 CIVIL  
 14 ROADS & MAPPING  
 15 DISTRICT ATTY OFFICE  
 16 FIRE CAPTAINS  
 17 POLICE PATROL  
 18 POLICE COMMAND  
 19 ATTORNEY  
 20 COUNTY COMMISSIONER  
 21 COUNTY COMM OFFICE  
 22 AIRPORT  
 23 SOLID WASTE RECYCLING  
 24 TRANSPORTATION  
 25 TREASURERS OFFICE  
 26 AMBULANCE  
 27 HOUSING  
 28 FIRE DEPARTMENT  
 29 PUBLIC WORKS  
 30 PROPERTY  
 31 PARKS AND RECREATION  
 32 POLICE DEPARTMENT  
 33 ASSESSORS  
 34 WELFARE  
 35 HEALTH  
 36 AUBURN ERF  
 37 COMMUNITY DEVELOPMENT  
 38 FINANCE DEPARTMENT  
 39 JOBS & BUSINESS  
 40 COUNTY BUILDING DEPT  
 41 CITY CLERKS  
 42 FOR ALL W/OUT DEPT CODE  
 43 MANAGERS  
 44 HIGHWAY AND SEWER  
 45 CONTROLLER  
 46 PLANNING DEPARTMENT  
 47 ADMIN WELFARE  
 48 MULTI PURPOSE  
 49 RECREATION  
 50 PRISONER SUPPORT  
 51 BOARD REGISTRATION  
 52 PARKING GARAGE  
 53 AUDITORS  
 54 LIBRARY  
 55 PERSONNEL  
 56 TREASURER  
 57 DATA PROCESS  
 58 SENIOR CITIZENS  
 59 ADMIN SERVICES  
 60 SEWER DEPARTMENT  
 61 COMMUNICATION  
 62 CODE ENFORCEMENT  
 63 FAMILY & COMMUNITY SERVICE  
 64 HEAT UTILITIES RENT  
 65 DEEDS OFFICE  
 70 PROBATE  
 71 OTHER  
 72 LANDFILL  
 73 DOMESTIC VIOLENCE  
 74 SAFESTART  
 75 SHERIFF DEPARTMENT  
 80 COMM.ADLT PROGRAM  
 81 MDEA  
 82 JAIL  
 83 SOIL CONVERSATION  
 84 SUPERIOR COURT  
 86 BUS SERVICE  
 87 CITY HALL  
 88 WATER POLLUTION  
 89 PARKS DEPARTMENT  
 90 CITY COUNCIL  
 91 EXECUTIVE  
 92 WATER AND SEWER  
 93 SCHOOL  
 94 JANITORIAL  
 95 WATER DISTRICT  
 96 CITY ENGINEER  
 97 TREATMENT  
 98 CEMETERY  
 99 SUPERVISORY

DEPARTMENT CODES BY ALPHA

59 ADMIN SERVICES  
 47 ADMIN WELFARE  
 22 AIRPORT  
 26 AMBULANCE  
 33 ASSESSORS  
 19 ATTORNEY  
 36 AUBURN ERF  
 53 AUDITORS  
 51 BOARD REGISTRATION  
 86 BUS SERVICE  
 98 CEMETERY  
 41 CITY CLERKS  
 90 CITY COUNCIL  
 96 CITY ENGINEER  
 87 CITY HALL  
 13 CIVIL  
 62  
 80 COMM.ADLT PROGRAM  
 61 COMMUNICATION  
 37 COMMUNITY DEVELOPMENT  
 45 CONTROLLER  
 11 CORRECTONS  
 40 COUNTY BUILDING DEPT  
 21 COUNTY COMM OFFICE  
 20 COUNTY COMMISSIONER  
 57 DATA PROCESS  
 65 DEEDS OFFICE  
 12 DISPATCH  
 15 DISTRICT ATTY OFFICE  
 73 DOMESTIC VIOLENCE  
 10 EMERGENCY MGMT AGCY  
 91 EXECUTIVE  
 63 FAMILY & COMMUNITY SERVICE  
 38 FINANCE DEPARTMENT  
 16 FIRE CAPTAINS  
 28 FIRE DEPARTMENT  
 35 HEALTH  
 64 HEAT UTILITIES RENT  
 44 HIGHWAY AND SEWER  
 27 HOUSING  
 82 JAIL  
 94 JANITORIAL  
 39 JOBS & BUSINESS  
 72 LANDFILL  
 54 LIBRARY  
 43 MANAGERS  
 81 MDEA  
 48 MULTI PURPOSE  
 71 OTHER  
 52 PARKING GARAGE  
 31 PARKS AND RECREATION  
 89 PARKS DEPARTMENT  
 55 PERSONNEL  
 46 PLANNING DEPARTMENT  
 18 POLICE COMMAND  
 32 POLICE DEPARTMENT  
 17 POLICE PATROL  
 50 PRISONER SUPPORT  
 70 PROBATE  
 30 PROPERTY  
 29 PUBLIC WORKS  
 49 RECREATION  
 14 ROADS & MAPPING  
 74 SAFESTART  
 93 SCHOOL  
 58 SENIOR CITIZENS  
 60 SEWER DEPARTMENT  
 75 SHERIFF DEPARTMENT  
 83 SOIL CONVERSATION  
 23 SOLID WASTE RECYCLING  
 84 SUPERIOR COURT  
 99 SUPERVISORY  
 24 TRANSPORTATION  
 56 TREASURER  
 25 TREASURERS OFFICE  
 97 TREATMENT  
 92 WATER AND SEWER  
 95 WATER DISTRICT  
 88 WATER POLLUTION  
 34 WELFARE  
 42 FOR ALL W/OUT DEPT CODE



**Maine Municipal  
Employees Health Trust**  
60 COMMUNITY DRIVE  
AUGUSTA, MAINE 04330-9486  
www.mmeht.org

# Sample #6

MMEHT OFFICE USE ONLY	
Subgroup No.	
Effective Date	
Status	
Entered by:	

## Medical Plan Application for Enrollment/Change

PLEASE PRINT

<b>EMPLOYER SECTION</b>	Employer _____		<b>Enrollment Reason:</b>		
	Date of Employment _____	Hours worked per week _____	<input type="checkbox"/> New Hire <input type="checkbox"/> Newly Eligible on _____ (date) <input type="checkbox"/> New Group (initial enrollment) <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Portability or Qualifying Event <input type="checkbox"/> Employer Change		
	Annual wages or salary _____	MMEHT Department Code _____			
<b>PLAN CHOICE</b>	<input type="checkbox"/> PPO _____ (indicate plan) <input type="checkbox"/> Point of Service _____ (indicate plan)				
<b>CHANGE STATUS</b>	Type of change <input type="checkbox"/> Name change <input type="checkbox"/> Add dependent <input type="checkbox"/> Drop dependent <input type="checkbox"/> Address change				
	Reason for change <b>Date of change or event</b> _____		<input type="checkbox"/> Previous Name _____ <input type="checkbox"/> Court order <input type="checkbox"/> Discharge from the Military <input type="checkbox"/> Entrance to the Military <input type="checkbox"/> Other _____		
<b>FAMILY INFORMATION</b>	You may apply to cover your legal spouse, domestic partner (DP) (provided your employer offers this benefit and the Trust receives a completed affidavit verifying qualification) and children between 19 and 26 years of age.				
	<b>Name (Last, First, MI)</b>	<b>Date of Birth</b> MO/DAY/YR	<b>Gender</b> M F	<b>Social Security Number</b>	<b>Primary Care Physician (PCP)</b> (www.anthem.com)
	Employee Name				PCP Full Name: _____ Current Patient? Y <input type="checkbox"/> N <input type="checkbox"/>
	<input type="checkbox"/> Spouse or <input type="checkbox"/> DP Name (check one)				PCP ID _____ PCP Full Name: _____ Current Patient? Y <input type="checkbox"/> N <input type="checkbox"/>
	Child Name				PCP ID _____ PCP Full Name: _____ Current Patient? Y <input type="checkbox"/> N <input type="checkbox"/>
	Child Name				PCP ID _____ PCP Full Name: _____ Current Patient? Y <input type="checkbox"/> N <input type="checkbox"/>
	Child Name				PCP ID _____ PCP Full Name: _____ Current Patient? Y <input type="checkbox"/> N <input type="checkbox"/>
<b>ADDRESS &amp; TELEPHONE</b>	Mailing Address _____			Telephone 1 _____	
	Town _____	State _____	Zip _____	Telephone 2 _____	
<b>SIGNATURE</b>	I am requesting coverage for me and all dependents listed, including any type of change selected in the Change Status section as indicated above. All statements and answers I have given are true and complete. I understand it is a crime to knowingly provide false, incomplete or misleading information to obtain insurance or benefits coverage for the purpose of defrauding the plan or insurance carrier. Penalties may include imprisonment, fines or denial of insurance benefits. I understand all benefits are subject to conditions stated in the Plan Document. I understand that, under a POS plan, each family member's care must be provided or arranged by his/her Primary Care Physician (PCP) except as described in my Summary Plan Description.				
	Employee Signature: _____			Date: _____	
<b>ELECTION NOT TO ENROLL</b>	<input type="checkbox"/> I elect not to enroll in medical coverage at this time. I understand that if I choose to enroll at a later date, enrollment may be available only during the open enrollment period, unless portability or special enrollment provisions apply.				
	NAME (PRINT) _____		EMPLOYER _____		
	SIGNATURE _____		DATE _____		

For questions, please call the Health Trust at 207-621-2645 or (within Maine) 800-852-8300



Maine Municipal  
Employees Health Trust  
60 COMMUNITY DRIVE  
AUGUSTA, MAINE 04330  
www.mmeht.org

MMEHT LIFE PLAN

Standard Insurance Co.  
Group Policy No. 648982

EMPLOYEE ENROLLMENT FORM

<b>Employer</b>	<b>Date of Hire</b>	<b>Annual Salary</b>
-----------------	---------------------	----------------------

Employee Name _____	Soc. Sec. # _____
Employee Address: _____	
Phone (H) _____ (W) _____	Gender ____ Marital Status ____ Date of Birth _____

**I would like to enroll in the following Life Insurance coverage(s):**

**Type of Coverage** – Check coverage and level option(s) desired only if offered by your employer

- Basic Life
- Life – No Medical
- Supplemental Life  Please enroll me for:  1x  2x  3x salary.
- Dependent Life  Please enroll me in:  Option A  Option B

**Dependent Information:** Complete only if enrolling in Dependent Life

Name	Date of Birth	Relationship

**Beneficiary Designation:** Note: Please designate each name as Primary (P) or Contingent (C) in last column

Name	Relationship	Address	Percentage	P or C

I hereby apply for life insurance to which I am entitled or to which I may become entitled under the terms of the group policy or policies issued to the Maine Municipal Employees Health Trust. If I do not elect the health coverage, I understand that I have the option to enroll in Basic Life for a monthly premium. I authorize the deduction from my earnings of any contribution I am required to make toward the cost of this insurance.

**Enrolling in Life Insurance:** Signature \_\_\_\_\_ Date: \_\_\_\_\_

I do not wish to enroll in **Basic Life** , **Supplemental Life** , or **Dependent Life** , at this time. I understand that if I do not enroll when I am first eligible, I will be subject to Evidence of Insurability at a later date. (Please check all appropriate boxes as indicated above.)

**Not Enrolling in Life:** Signature \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE READ IMPORTANT INFORMATION ON THE NEXT PAGE**



**Maine Municipal  
Employees Health Trust**  
60 COMMUNITY DRIVE  
AUGUSTA, MAINE 04330-9486  
www.mmeht.org

MMEHT OFFICE USE ONLY
Subgroup No.
Effective Date
Status
Entered by:

**INCOME PROTECTION PLAN  
Application for Enrollment**  
207-623-8428 or (within Maine) 800-452-8786

<b>EMPLOYER SECTION</b>	Employer		<b>Enrollment Reason:</b> <input type="checkbox"/> New Hire <input type="checkbox"/> Newly Eligible on _____ (date) <input type="checkbox"/> New Group (initial enrollment) <input type="checkbox"/> Increase/Decrease Coverage <input type="checkbox"/> Late Enrollee
	Date of Employment	Hours worked per week	
	Annual wages or salary	MMEHT Department Code	
	Is employee actively working as of the effective date of coverage, or available to work if it is not a regularly scheduled work day? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Employer Signature: _____ Title: _____			

**Employee: Complete this section only if you are enrolling in the Income Protection Plan coverage.  
If you do not wish to enroll, please complete the "Election Not to Enroll" section below.**

<b>PLAN CHOICE</b>	I elect to be insured at <input type="checkbox"/> 40% <input type="checkbox"/> 55% <input type="checkbox"/> 70% of salary as a weekly benefit and hereby authorize my employer to withhold from payroll the amount necessary to make coverage effective.			
<b>NAME, ADDRESS &amp; TELEPHONE</b>	Employee Name	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number
	Mailing Address			Telephone 1
	Town	State	Zip	Telephone 2
<b>SIGNATURE</b>	I am requesting coverage, or a change in coverage, for myself. All statements and answers I have given are true and complete. I understand it is a crime to knowingly provide false, incomplete or misleading information to obtain insurance or benefits coverage for the purpose of defrauding the plan or insurance carrier. Penalties may include imprisonment, fines or denial of insurance benefits. I understand all benefits are subject to conditions stated in the Plan Document.  Employee Signature: _____ Date: _____			

<b>ELECTION NOT TO ENROLL</b>	<input type="checkbox"/> I elect not to enroll in Income Protection coverage at this time, and understand that if I apply at a future date, enrollment may not be permissible without evidence of good health.		
	NAME (print) _____	EMPLOYER _____	
	SIGNATURE _____	DATE _____	

# Sample #9a



Underwritten by:  
Unum Life Insurance Company of America  
2211 Congress Street, Portland, ME 04122

**Maine Municipal Employees  
Health Trust**  
Long Term Disability Insurance  
Enrollment Form  
**Policy # 588949**

Employee Name:	Occupation:	
Social Security Number: ___ - ___ - ____	Date of Birth: ___ / ___ / ____	
Hours Worked/Week:	Gender:	Location:
Date of Hire: ___ / ___ / ____	Annual Salary:	

I understand the effective date of my coverage will be delayed if I am not in active employment because of an injury, sickness, temporary lay-off or leave of absence on the date this insurance would otherwise become effective. **I have also read and understand the information in the Plan Highlights, including all statements regarding exclusions and benefit amounts and offsets.** My signature verifies the accuracy of information contained on this form.

Employee Signature: \_\_\_\_\_

Date: \_\_\_ / \_\_\_ / \_\_\_\_

Return Forms To: YOUR PLAN ADMINISTRATOR

**This section to be completed by your employer:**

Coverage Effective Date: \_\_\_ / \_\_\_ / \_\_\_\_



Underwritten by:  
 Unum Life Insurance Company of America  
 2211 Congress Street, Portland, ME 04122

**Maine Municipal Employees  
 Health Trust**  
 Long Term Disability Insurance  
 Enrollment Form  
**Policy # 588982**

Employee Name:	Occupation:	
Social Security Number: ____ - ____ - ____	Date of Birth: ____ / ____ / ____	
Hours Worked/Week:	Gender:	Location:
Date of Hire: ____ / ____ / ____	Annual Salary:	

Rates* per \$100 of Covered Salary			
Age	Rate	Age	Rate
< 25	\$0.23	50 - 54	\$0.94
25 - 29	\$0.27	55 - 59	\$1.09
30 - 34	\$0.31	60 - 64	\$1.50
35 - 39	\$0.39	65 - 69	\$1.64
40 - 44	\$0.52	70 +	\$1.87
45 - 49	\$0.70		

\*LTD rates are based on five-year increments. Rates increase as you age.

To calculate the per-paycheck cost for this coverage, complete the calculations below.

Note: If your annual salary exceeds \$120,000.00, use \$120,000.00 as your annual salary in the calculation.

$$\frac{\text{Annual Salary}}{100} = \text{____} \times \frac{\text{Your Rate}}{\text{Your Annual Cost}} = \frac{\text{____}}{\text{____}} + \frac{12}{\text{# of Paychecks per Year}} = \text{Your Monthly Cost*}$$

\* Final cost may vary slightly due to rounding.

**Yes**, I would like to participate. I authorize my employer to deduct from my salary or wages the necessary premium for this coverage. My signature verifies the accuracy of information contained on this form.

I understand the effective date of my coverage will be delayed if I am not in active employment because of an injury, sickness, temporary lay-off or leave of absence on the date this insurance would otherwise become effective. **I have also read and understand the information in the Plan Highlights, including all statements regarding exclusions and benefit amounts and offsets.**

**No**, I do not wish to participate. I understand that evidence of insurability will be required, at my own expense, if I decide to elect this coverage in the future.

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Return Forms To: YOUR PLAN ADMINISTRATOR

**This section to be completed by your employer:**

Coverage Effective Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

# Sample #10



**Maine Municipal  
Employees Health Trust**  
60 COMMUNITY DRIVE  
AUGUSTA, MAINE 04330-9486  
www.mmeht.org

MMEHT OFFICE USE ONLY	
Subgroup No.	
Effective Date	
Status	
Entered by:	

## Dental Plan Application for Enrollment/Change

<b>EMPLOYER SECTION</b>	Employer _____	Date of Employment _____	Hours worked per week _____
<b>ENROLLMENT REASON</b>	<input type="checkbox"/> New Hire <input type="checkbox"/> Newly Eligible on _____ (date) <input type="checkbox"/> New Group (initial enrollment) <input type="checkbox"/> Portability or Qualifying Event		
<b>CHANGE STATUS</b>	Type of change: <input type="checkbox"/> Name change <input type="checkbox"/> Add dependent <input type="checkbox"/> Drop dependent <input type="checkbox"/> Address change  Reason for change, <b>Date of change or event</b> _____ <input type="checkbox"/> Adoption <input type="checkbox"/> Birth <input type="checkbox"/> Court order <input type="checkbox"/> Covered by other insurance <input type="checkbox"/> Death <input type="checkbox"/> Discharge from the Military <input type="checkbox"/> Divorce <input type="checkbox"/> Dissolution of Domestic Partnership <input type="checkbox"/> Entrance to the Military <input type="checkbox"/> Involuntary loss of coverage <input type="checkbox"/> Marriage <input type="checkbox"/> Other _____		
<b>FAMILY INFORMATION</b>	You may apply to cover your legal spouse, domestic partner (DP) (provided your employer offers this benefit and the Trust receives a completed affidavit verifying qualification) and unmarried children under 19 years of age. You may also apply to cover your children between 19 and 25 if they are unmarried and dependent on you for support, though special forms may be sent to you to complete.		
	<b>Name (Last, First, MI)</b>	<b>Date of Birth</b> MO/DA/YR	<b>Gender</b> M F
	Employee Name _____		
	<input type="checkbox"/> Spouse or <input type="checkbox"/> DP Name (check one)		
	Child Name _____		
	Child Name _____		
	Child Name _____		
<b>ADDRESS &amp; TELEPHONE</b>	Mailing Address _____	Telephone 1 _____	
	Town _____ State _____ Zip _____	Telephone 2 _____	
<b>OTHER COVERAGE</b>	Is your spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you or your dependents have other dental insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	If yes, name of insurance _____	Certificate Number _____	Policyholder _____
	Name(s) of covered individual(s) _____	If coverage is recently terminated, state reason and date of loss: _____	
<b>SIGNATURE</b>	I am requesting coverage for myself and all dependents listed. All statements and answers I have given are true and complete. I understand it is a crime to knowingly provide false, incomplete or misleading information to obtain insurance or benefits coverage for the purpose of defrauding the plan or insurance carrier. Penalties may include imprisonment, fines or denial of insurance benefits. I understand all benefits are subject to conditions stated in the Plan Document.		
	Employee's Signature: _____	Date: _____	

<b>ELECTION NOT TO ENROLL</b>	<input type="checkbox"/> I elect not to enroll at this time and understand that if I apply at a future date, enrollment may not be permissible without evidence of good dental health.		
	<input type="checkbox"/> I elect not to enroll my dependents at this time and understand that if I apply at a future date, enrollment may not be permissible without evidence of good dental health.		
	NAME (PRINT) _____	EMPLOYER _____	
	SIGNATURE _____	DATE _____	



**Maine Municipal  
Employees Health Trust**  
60 COMMUNITY DRIVE  
AUGUSTA, MAINE 04330-9486  
www.mmeht.org



MMEHT OFFICE USE ONLY	
Subgroup No.	
Effective Date	
Status	
Entered by:	

## VSP VISION PLAN Application for Enrollment/Change

<b>EMPLOYER SECTION</b>	Employer	<b>Enrollment Reason:</b> <input type="checkbox"/> New Hire <input type="checkbox"/> Newly Eligible on _____ (date) <input type="checkbox"/> New Group (initial enrollment) <input type="checkbox"/> Open Enrollment
	Date of Employment	

**Employee: Complete this section only if you are enrolling in the Vision Plan coverage.  
If you do not wish to enroll, please complete the "Election Not to Enroll" section below.**

<b>PLAN CHOICE</b>	I elect to be insured at <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child <input type="checkbox"/> Family coverage and hereby authorize my employer to withhold from payroll the amount necessary to make coverage effective.			
<b>NAME, ADDRESS &amp; TELEPHONE</b>	Employee Name	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number
	Mailing Address			Telephone 1
	Town	State	Zip	Telephone 2

You may apply to cover your legal spouse, domestic partner (DP) (provided your employer offers this benefit and the Trust receives a completed affidavit verifying qualification) and unmarried children under 19 years of age. You may also apply to cover your children between 19 and 25 if they are unmarried and dependent on you for support, though special forms may be sent to you to complete.

<b>CHANGE STATUS</b>	Type of change: <input type="checkbox"/> Name change <input type="checkbox"/> Add dependent <input type="checkbox"/> Drop dependent <input type="checkbox"/> Address change	
	Reason for change. <b>Date of change or event</b> _____ <input type="checkbox"/> Adoption <input type="checkbox"/> Birth <input type="checkbox"/> Court order <input type="checkbox"/> Covered by other insurance <input type="checkbox"/> Death <input type="checkbox"/> Discharge from the Military <input type="checkbox"/> Divorce <input type="checkbox"/> Dissolution of Domestic Partnership <input type="checkbox"/> Entrance to the Military <input type="checkbox"/> Involuntary loss of coverage <input type="checkbox"/> Marriage <input type="checkbox"/> Other _____	

<b>FAMILY INFORMATION (IF ELECTING FAMILY COVERAGE)</b>	Name (Last, First, MI)	Date of Birth Month/Day/Year	Gender	
			Male	Female
<input type="checkbox"/> Spouse or <input type="checkbox"/> DP (check one)				
Child				
Child				
Child				

<b>SIGNATURE</b>	I am requesting coverage for myself and all dependents listed. All statements and answers I have given are true and complete. I understand it is a crime to knowingly provide false, incomplete or misleading information to obtain insurance or benefits coverage for the purpose of defrauding the plan or insurance carrier. Penalties may include imprisonment, fines or denial of insurance benefits. I understand all benefits are subject to conditions stated in the Plan Document.	
	Employee Signature: _____	Date: _____

<b>ELECTION NOT TO ENROLL</b>	<input type="checkbox"/> I elect not to enroll in VSP Vision coverage at this time. I understand that if I choose to enroll at a later date, enrollment will only be available during the open enrollment period.	
	NAME (print) _____	EMPLOYER _____
	SIGNATURE _____	DATE _____

**For questions, please call the Health Trust at 207-621-2645 or (within Maine) 1-800-852-8300**



Maine Municipal  
 Employees Health Trust  
 60 COMMUNITY DRIVE  
 AUGUSTA, MAINE 04330-9486  
 (207) 621-2645

# Sample #12

May 4, 2012  
 "+19" Dependent  
Application for Continued Coverage  
 Health and/or Dental

Insured Name: Ben E. Fitz	<b>For Office Use Only</b>
Insured ID Number: A0001234	
Address: 25 Municipal Lane Anywhere, ME 04000 If address has changed, please print changes above.	<input type="checkbox"/> +19 Dependent <input type="checkbox"/> Deleted date: _____
Name of +19 Dependent  Hissie Fitz	MHT.99999

Please answer the questions below and sign your name.

- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| 1. Do you want your dependent to remain on your contract as a +19 dependent? If NO, please answer question 3, sign and return. If YES, please answer remaining questions.                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Is he/she totally and permanently disabled due to physical or mental condition(s)? If yes, we will send you a Medical Certification form to be completed by you and your child's physician. | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Does he/she have other health, dental or vision insurance coverage?<br>If yes: Name of Insured: _____ Policy #: _____<br>Effective Date: _____ Insurance Co. Name: _____                    | <input type="checkbox"/> | <input type="checkbox"/> |

### PARTICIPANT CERTIFICATION

As a participant in the Maine Municipal Employees Health Trust, I hereby certify, under penalty of perjury, that the information provided above is true, accurate and complete as of the date hereof, and I agree to advise the Trust if any of the facts specified above change. I further understand that the Trust will rely on this information in providing coverage to my dependent and that any material falsehood or inaccuracy may result in the disallowance and non-payment of dependent claims.

\_\_\_\_\_  
 Date Signature of Participant



Maine Municipal  
Employees Health Trust  
60 COMMUNITY DRIVE  
AUGUSTA, MAINE 04330-9486  
www.mmeht.org

Standard Insurance Company  
Group Policy No. 648982

## MMEHT LIFE PLAN EMPLOYEE CHANGE FORM

1. TYPE OF CHANGE	Beneficiary Change <input type="checkbox"/>	Name Change <input type="checkbox"/> Previous Name: _____	Address Change <input type="checkbox"/>	Benefit Change <input type="checkbox"/>
-------------------	---	--	---	---

2. EMPLOYER SECTION	Employer: _____	Date of Hire: _____	Annual Salary: \$ _____
---------------------	-----------------	---------------------	-------------------------

3. EMPLOYEE SECTION	Employee Name: _____ Soc. Sec. #: _____		
	Employee Address: _____		
	Phone (H): _____ (W): _____	Gender: _____	Marital Status: _____ Date of Birth: _____

4. PLAN OPTIONS	I would like to change my Life Insurance coverage(s) as specified below (you may only select coverage options offered by your employer):		
	<u>Type of Coverage</u>	<u>Add</u>	<u>Drop</u> <u>Level</u>
	Basic Life	<input type="checkbox"/>	<input type="checkbox"/> N/A
	Supplemental Life	<input type="checkbox"/>	<input type="checkbox"/> 1x salary <input type="checkbox"/> 2x salary* <input type="checkbox"/> 3x salary*
	Dependent Life	<input type="checkbox"/>	<input type="checkbox"/> Option A <input type="checkbox"/> Option B      * Requires Evidence of Insurability
	Specify Change: _____		

NOTE: PLEASE DESIGNATE EACH NAME AS PRIMARY (P) OR CONTINGENT (C) IN LAST COLUMN

5. BENEFICIARY DESIGNATION	Name	Relationship	Address	Percentage	P or C

NOTE: COMPLETE ONLY IF ENROLLING IN DEPENDENT LIFE

6. DEPENDENT INFORMATION	Name	Date of Birth	Relationship

7. AUTHORIZED SIGNATURE	I hereby apply for life insurance to which I am entitled or to which I may become entitled under the terms of the group policy or policies issued to the Maine Municipal Employees Health Trust. I authorize the deduction from my earnings of any contribution I am required to make toward the cost of this insurance.	
	SIGNATURE: _____	DATE: _____

**PLEASE READ IMPORTANT INFORMATION ON THE NEXT PAGE**

**MAINE MUNICIPAL EMPLOYEES HEALTH TRUST**

**EMPLOYER STATEMENT REGARDING**

**RETIREE ELIGIBILITY FOR**

**CONTINUED HEALTH INSURANCE**

Employee Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employee SS#: \_\_\_\_\_ Date of Retirement: \_\_\_\_\_

- YES \_\_\_\_\_ NO \_\_\_\_\_      1. Has the employee been employed by, or been an elected or appointed official with, this employer for the last five (5) consecutive years?
- YES \_\_\_\_\_ NO \_\_\_\_\_      2. On the date of retirement was the employee at least 55 years old?
- YES \_\_\_\_\_ NO \_\_\_\_\_      3. Will the employee be receiving benefits from the Maine State Retirement System?
- YES \_\_\_\_\_ NO \_\_\_\_\_      4. Will the employee be receiving retirement benefits from a plan (other than MSRS) established by this employer?

This form must be completed and sent in with your bill, payment and termination form.

\_\_\_\_\_  
Name of Employer

\_\_\_\_\_  
Signature by Official Employer

\_\_\_\_\_  
Date



**Maine Municipal  
Employees Health Trust**  
60 COMMUNITY DRIVE  
AUGUSTA, MAINE 04330-9486  
www.mmeht.org

MMEHT OFFICE USE ONLY	
Group Number	Subgroup Number
Effective Date	Plan Type

## Health Plan Application for Continued Enrollment as a Retiree

**207-621-2645 or (within Maine) 800-852-8300**  
**Fax: 207-624-0166**

PLEASE PRINT.

<b>1. FAMILY INFORMATION</b>	<p>You may apply to cover your legal spouse and children less than 19 years of age. You may also apply to cover your children between 19 and 26. Special forms may be sent to you to complete.</p>					
	Name (Last, First, MI)	Date of Birth MO/DAYR	Gender M F	Social Security Number	Primary Care Physician (PCP) (www.anthem.com or see Anthem Directory)	Current Patient?
	Retiree				PCP Name: _____	Y <input type="checkbox"/> N <input type="checkbox"/>
					PCP ID:	
	Spouse				PCP Name: _____	Y <input type="checkbox"/> N <input type="checkbox"/>
					PCP ID:	
	Dependent				PCP Name: _____	Y <input type="checkbox"/> N <input type="checkbox"/>
					PCP ID:	
	Dependent				PCP Name: _____	Y <input type="checkbox"/> N <input type="checkbox"/>
					PCP ID:	
<b>2. ADDRESS &amp; TELEPHONE</b>	Mailing Address				Home Telephone	
	City/Town	State	Zip	Mobile Telephone		
<b>3. MEDICARE INFORMATION</b>	<b>Refer to your Medicare Health Insurance card for Claim Number and Effective Dates.</b>					
	Is anyone listed on this application currently eligible for Medicare?					
	<input type="checkbox"/> <b>Yes</b> Please complete the following for each person to be covered who has Medicare A&B. <input type="checkbox"/> <b>No</b> Please disregard this section.					
	<b>Retiree</b>			<b>Spouse</b>		
	Medicare Claim Number _____ (letter)			Medicare Claim Number _____ (letter)		
	EFFECTIVE DATES			EFFECTIVE DATES		
	Month		Year	Month		Year
	HOSPITAL (PART A)			HOSPITAL (PART A)		
	MEDICAL (PART B)			MEDICAL (PART B)		
	REASON(S) FOR MEDICARE			REASON(S) FOR MEDICARE		
	Age 65	Disability	ESRD*	Age 65	Disability	ESRD*
	Check All Applicable			Check All Applicable		
	* End Stage Renal Disease			* End Stage Renal Disease		
<b>4. SIGNATURE</b>	<p>I am requesting coverage, or a change in coverage, for myself and dependents listed. All statements and answers I have given are true and complete. I understand it is a crime to knowingly provide false, incomplete or misleading information to obtain insurance or benefit coverage for the purpose of defrauding the plan or insurance carrier. Penalties may include imprisonment, fines or denial of insurance benefits. I understand all benefits are subject of conditions stated in the Plan Document.</p>					
	Retiree Signature: _____				Date: _____	



**Maine Municipal  
Employees Health Trust**  
60 COMMUNITY DRIVE  
AUGUSTA, MAINE 04330-9408

(207) 623-8428  
1-800-452-8786

## MSRS Deduction Authorization

PLEASE PRINT

Subscriber Name		Date of Birth Month   Day   Year			Social Security Number			
Spouse Name		Date of Birth Month   Day   Year			Social Security Number			
Address: Street		City		State		Zip Code		
I hereby authorize the Maine State Retirement System to deduct the proper amount to cover the costs of my health care coverage.								
Subscriber Signature:				Date:				
<b>Office Use Only:</b>	CERTIFICATE NUMBER		Retirement Payroll			BC/BS or HMO Maine		
	GROUP NUMBER		Effective Date			Effective Date		
81321			Month	Day	Year	Month	Day	Year

Original — BC

Copy 1 — MSRS

Copy 2 — MMEHT

HT002



Maine Municipal  
Employees Health Trust  
60 COMMUNITY DRIVE  
AUGUSTA, MAINE 04330-9486  
(207) 621-2645

Sample #17

## CERTIFICATE OF GROUP MEDICAL PLAN COVERAGE

### Statement of HIPAA Portability Rights

**IMPORTANT – KEEP THIS CERTIFICATE.** This certificate is evidence of your coverage under this plan. Under a federal law known as HIPAA, you may need evidence of your coverage to reduce a preexisting condition exclusion period under another plan, to help you get special enrollment in another plan, or to get certain types of individual health coverage even if you have health problems.

1. Date of this certificate: April 8, 2011
2. Name of group medical plan: Maine Municipal Employees Health Trust
3. Name of participant: Ben E. Fitz
4. Identification number of participant: 123-45-6789
5. Name and start date of any dependents to whom this certificate applies:  
Hissie Fitz                      August 1, 2006
6. Name, address, and telephone number of plan administrator or issuer responsible for providing this certificate:  
Maine Municipal Employees Health Trust  
60 Community Drive  
Augusta, ME 04330  
1-800-452-8786 in Maine or (207) 623-8428
7. For further information, call: Billing Enrollment Department
8. If the individual(s) identified in line 3 and line 5 has at least 18 months of creditable coverage (disregarding periods of coverage before a 63-day break), check here  and skip lines 9 and 10.
9. Date waiting period or affiliation period (if any) began: \_\_\_\_\_
10. Date coverage began: August 1, 2006
11. Date coverage ended: April 1, 2011 (or check if coverage is continuing as of the date of this certificate: ).

*Note:* Separate certificates will be furnished if information is not identical for the participant and each beneficiary.

# Sample #18

## Certificate of Coverage (cont.)

**Preexisting condition exclusions.** Some group medical plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "preexisting condition exclusions." A preexisting condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a preexisting condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a preexisting condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

If a plan imposes a preexisting condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group medical plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. Not all forms of creditable coverage are required to provide certificates like this one. If you do not receive a certificate for past coverage, talk to your new plan administrator.

You can add up any creditable coverage you have, including the coverage shown on this certificate. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

- Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day break. You may use this certificate as evidence of your creditable coverage to reduce the length of any preexisting condition exclusion if you enroll in another plan.

**Right to get special enrollment in another plan.** Under HIPAA, if you lose your group medical plan coverage, you may be able to get into another group medical plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

- Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

**Prohibition against discrimination based on a health factor.** Under HIPAA, a group medical plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group medical plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

**Right to individual health coverage.** Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a preexisting condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group medical plan (which can be shown by this certificate);
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- You are not eligible for another group medical plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

- Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

**Special information for people on FMLA leave.** If you are taking leave under the Family and Medical Leave Act (FMLA) and you drop health coverage during your leave, any days without health coverage while on FMLA leave will not count towards a 63-day break in coverage. In addition, if you do not return from leave, the 30-day period to request special enrollment in another plan will not start before your FMLA leave ends.

- Therefore, when you apply for other health coverage, you should tell your plan administrator or health insurer about any prior FMLA leave.

**State flexibility.** This certificate describes minimum HIPAA protections under federal law. States may require insurers and HMOs to provide additional protections to individuals in that state.

**For more information.** If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at 1-866-444-3272 (for free HIPAA publications ask for publications concerning changes in health care laws). You may also contact the CMS publication hotline at 1-800-633-4227 (ask for "Protecting Your Health Insurance Coverage"). These publications and other useful information are also available on the Internet at: <http://www.dol.gov/ebsa>, the DOL's interactive web pages – Health Elaws, or <http://www.cms.hhs.gov/hipaa1>.

## Standard Insurance Company

Continued Benefits  
920 SW Sixth Avenue Portland OR 97204 800.378.4668 ext 6785

## Request for Group Life Conversion Materials

### Important Information for Owners of Group Life Insurance Certificates

We are happy to inform you that under your Standard Insurance Company Group Life Insurance coverage, you and your insured dependents are offered the benefit of obtaining an individual life insurance policy. In order to take advantage of this opportunity, we must receive an application and premium payment within 60 days of the date of cessation or reduction of group life insurance coverage. This option to convert may be very valuable to you, as evidence of insurability will not be required. To take advantage of the privilege of converting your insurance, please complete and return this form to the address above. We will provide the necessary forms and information. For your convenience, at your election, we can send the information electronically to your email address or we can mail the forms to your street address.

### Member Information

Member's Name		Today's Date	
Insured's Name, if different		Phone (     )	
Member's Address	City	State	Zip
Email Address			
Please indicate the applications you will need. <input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child - No. of children: _____		Please send application forms via: <input type="checkbox"/> Email <input type="checkbox"/> Regular Mail	
Group Name and Policy No. <b>Maine Municipal Employees Health Trust - 648982</b>		Termination or Reduction Date of Insurance	

Standard Insurance Company  
 800.378.4668 ext. 6785 800.331.3397 Fax  
 920 SW Sixth Avenue Portland OR 97204-1203

**Maine Municipal Employees Health Trust  
 Member Statement for Group Life  
 Portability Insurance**

Please type or print. COMPLETE ENTIRE FORM.

**1. MEMBER INFORMATION**

Name (last, first, middle)		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Street address	City	State	Zip code
Social Security No.	Telephone	Birthdate (month, day, year)	

**2. DEPENDENTS INFORMATION (if applicable)**

Spouse name (last, first, middle)	Spouse birthdate (month, day, year)
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**3. EMPLOYER INFORMATION**

Name of group <b>Maine Municipal Employees Health Trust</b>	Group Number <b>648982</b>
Name of employer (if different)	Employer HR Contact and Phone Number
Your occupation with the employer	
Date you last worked for the employer	Employment termination date (if different)
If date you last worked and employment termination date differ, please explain:	

**4. ELIGIBILITY**

Date you became insured under your Employer's coverage under the Group Policy
Have you been insured under your Employer's group life insurance plan for at least 12 consecutive months? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is your employment terminating due to medical reasons? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you able to perform with reasonable continuity the material duties of at least one gainful occupation for which you are reasonably fitted by education, training and experience? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you under the age of 65 on the date your employment terminates? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you or your spouse used tobacco in any form in the last 12 months? Member: <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No

**5. AMOUNT OF INSURANCE COVERAGE REQUESTED**

GROUP LIFE and, if applicable, DEPENDENTS LIFE INSURANCE		AD&D INSURANCE (if applicable)
Member	\$	\$
Spouse	\$	\$
Children	\$	

Billing: If approved, you will be billed quarterly (every three months), at your home address. Premiums must be received by the due date.

(continued)

## COBRA Election Form

**To elect COBRA continuation of group health coverage, complete this Election Form and return it to:**

**Maine Municipal Employees Health Trust**  
**Attn: Billing and Enrollment Department**  
**60 Community Drive, Augusta, ME 04330-9486.**

You have the later of 60 days from the date of this notice or 60 days from the loss of coverage to decide to elect COBRA continuation coverage under the Plan. The last date you are able to elect COBRA coverage is «Return Date». This form must be returned by mail and postmarked no later than «Return Date».

**If you do not return the completed Election Form by the date shown above, you will lose your right to elect COBRA coverage. If you reject COBRA coverage before the due date shown above, you may change your mind as long as you furnish a completed Election form before the due date. However, if you change your mind after first rejecting COBRA coverage, your COBRA coverage will begin on the date the Health Trust receives the completed form. In this case, there may be a lapse of coverage.**

Your monthly COBRA continuation of coverage premium will be:

PLAN TYPE	PLAN NAME	RATE CATEGORY	MONTHLY PREMIUM
Medical	POS-C	Family	\$«HPremium»
Dental		«DCoverage»	\$«DPremium»
Vision		«VCoverage»	\$«VPremium»

You do not have to send any payment with the Election form. Important additional information about COBRA premium payment is included in pages following the Election Form.

**Please read the important information regarding your COBRA rights included in the pages following this Election Form.**

Insured:	Ben E. Fitz	Division No.	MHT.99999
Insured ID:	123-45-6789	Dependent of:	
COBRA Effective Date:	April 1, 2011	COBRA Termination Date:	October 1, 2012

**1. For Insured:**

I certify, as the subscriber, that I am aware of the continuation of benefits available under my current medical plan and the extent to which those benefits can be continued at my expense. (Check one.)

Yes \_\_\_\_, I elect to continue Health \_\_ Dental \_\_ Vision coverage \_\_. No \_\_\_\_, I do not wish to continue coverage.

**INSURED'S SIGNATURE:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**2. For Insured's Spouse:**

I certify, as the subscriber's covered spouse, that I am aware of the continuation of benefits available under my current medical plan and the extent to which those benefits can be continued at my expense. (Check one.)

Yes \_\_\_\_, I elect to continue Health \_\_ Dental \_\_ Vision coverage \_\_. No \_\_\_\_, I do not wish to continue coverage.

**SPOUSE'S SIGNATURE:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**3. For Insured's Dependents:**

I certify, as the parent or legal guardian for my covered dependents, that they are aware of the continuation of benefits available under their current medical plan and the extent to which those benefits can be continued at my expense. (Check one.)

Yes \_\_\_\_, I elect to continue Health \_\_ Dental \_\_ Vision coverage \_\_. No \_\_\_\_, I do not wish to continue coverage.

**PARENT OR LEGAL GUARDIAN'S SIGNATURE:** \_\_\_\_\_ **Date:** \_\_\_\_\_

ARE ANY OF THE FOLLOWING ENROLLED IN: (Please answer for each group)					
<u>ANOTHER GROUP COVERAGE</u>			<u>MEDICARE BENEFITS</u>		
Employee	Yes ____	No ____	Employee	Yes ____	No ____
Spouse	Yes ____	No ____	Spouse	Yes ____	No ____
Dependents	Yes ____	No ____	Dependents	Yes ____	No ____

# Sample #21

Insured Name:	Ben E. Fitz	Group:	Town of Trustville
Spouse/Dependent Name:		Date:	
Dependent of:			

## COBRA ELECTION NOTICE

**This notice contains important information about your right to continue your healthcare coverage in the Maine Municipal Employees Health Trust group health insurance plan. This notice also contains information regarding the extension or conversion of other Plan benefits. Please read the information contained in this notice and in the following pages very carefully.**

To elect COBRA healthcare continuation coverage, follow the instructions on the next page to complete the enclosed Election Form and return it to the Maine Municipal Employees Health Trust.

If you do not elect COBRA continuation coverage, your Health Trust group health insurance coverage will end on «Employee end date» due to the reason checked below. Please note that the period of time that you are eligible for COBRA continuation of group health care coverage is included under each situation.

- Termination of employment, temporary layoff, or reduction in employee's hours making you and/or your covered dependents ineligible for the MMEHT Medical Plan, or other reason not shown herein. (All enrolled members may continue group health care coverage for up to 18 months.)
- Divorce or legal separation of the spouse from the employee. (The non-employee spouse and any covered dependent children may continue group health care coverage for up to 36 months.)
- Loss of employment due to work related injury or occupational disease. (The employee and any covered dependents may continue group healthcare coverage for up to 18 months.)
- A dependent child ceases to be a dependent child under the generally applicable rules of the medical plan. (The dependent child may elect to continue group healthcare coverage for up to 36 months.)
- Termination of employment due to disability; or disability occurring within 60 days after termination of employment, reduction in employee's hours making you and/or your dependents ineligible for the MMEHT Medical Plan, or temporary leave. (All enrolled members may continue group healthcare coverage for up to 18 months with possible extension to 29 months at higher rates, based upon Medicare determination and notification to MMEHT within 60 days of the determination and prior to the 18 months expiring.) The MMEHT must also be notified within 30 days of the date your disability ends.
- The employee becomes eligible for Medicare and elects Medicare coverage rather than the regular group coverage; and the employer does not allow any remaining dependents to remain on the employer billing. (The covered spouse, if not also enrolled in Medicare, and any covered dependent children may continue group healthcare coverage for the greater of 18 months from the employee termination or reduction in hours or 36 months from the date of entitlement.)
- The employee leaves employment on account of a uniformed services leave under USERRA making you and your dependents eligible for up to 24 months of continuation coverage under either COBRA or USERRA.

If elected, COBRA continuation of coverage will begin on April 1, 2011 and may last up to October 1, 2012.

If you have any questions about any information contained in this notice or your rights to COBRA continuation coverage, you should contact a Health Trust Billing and Enrollment Representative at 207-621-2645 (local) or toll free at 1-800-852-8300 Monday through Friday from 8:00 AM to 4:30 PM. You should mail written correspondence to Maine Municipal Employees Health Trust, 60 Community Drive, Augusta, Maine 04330.