

Maine Municipal Employees Health Trust

Health Plan Authorization

In making application for Maine Municipal Employees Health Trust (the Health Trust) health coverage, I agree to the following conditions for myself and my covered dependents under the age of 18. My spouse's signature, and the signature of any dependent over the age of 18, authorizes the release of his/her Confidential Information (as described below) and adherence to the policies as outlined below.

All statements and answers furnished by me are true and complete to the best of my knowledge. I understand it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. I understand that my employer will take any required periodic deductions from my pay as my contribution toward premiums due.

I understand that the benefits I am applying for are subject to the terms and conditions stated in the applicable Health Trust Plan Document and that benefits will be coordinated with other health or insurance programs. I understand that I am subject to the Plan's subrogation rights and responsibilities, as defined by the Plan in the applicable Health Trust Plan Document and/or Summary Plan Description. Any dispute of claim will be resolved by the grievance procedures established in the applicable Health Trust Plan Document.

I authorize Maine Municipal Employees Health Trust (and its Third Party Administrators) to request copies of Confidential Information about me, or my covered dependent children, from all health care providers, third party payers, utilization review agencies, and state or federal agencies, for the purpose of administering my benefits. I understand that for the purpose of this release, Confidential Information is defined as medical, dental, mental health, substance abuse, and eligibility related information, as allowed by state and federal law. Any Confidential Information collected will be used primarily to determine eligibility for benefits under the Health Trust, but may also be used by the Third Party Administrator(s) to conduct utilization review, quality assurance, case or care management, Plan administration or benefit administration, without my authorization, in accordance with Maine law. The Confidential Information requested will be limited to that information which is reasonably required to administer my benefits. I understand any such information will be used only after issuance of coverage and will have no effect on determination of eligibility to enroll.

I understand that I, or my dependents, have the right to access and correct any personal information collected by Maine Municipal Employees Health Trust or their designees, according to Maine law.

I give this consent for myself and any eligible family members listed on this application for whom I am authorized to do so. I understand that failure to sign this authorization may be the basis for enrollment or benefit denial. I understand I am entitled to receive a copy of this authorization. I further understand that my signature is valid for the term of coverage of this policy and any renewals and that I have the right to revoke the authorization by written notice to Maine Municipal Employees Health Trust. I understand that such revocation of this authorization may be a basis for denying coverage of services.

For the Point of Service Plan, I fully understand that to receive reimbursement at the in-network benefit payment level, the chosen Primary Care Physician(s) must provide or authorize all medical and hospital care except for emergency care.