



**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

EMPLOYER SECTION	Employer _____	Date of Employment _____	Hours worked per week _____	
ENROLLMENT REASON	<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			
CHANGE STATUS	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. Date of change or event _____ <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 _____			
FAMILY INFORMATION	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.			
	Name (Last, First, MI)	Date of Birth MO/DA/YR	Gender M F	Social Security Number
	Employee Name _____			
	<input type="checkbox"/> Spouse or <input type="checkbox"/> DP Name (check one)			
	Child Name _____			
	Child Name _____			
ADDRESS & TELEPHONE	Mailing Address _____		Telephone 1 _____	
	Town _____	State _____ Zip _____	Telephone 2 _____	
OTHER COVERAGE	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. _____	
SIGNATURE	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: _____	

ELECTION NOT TO ENROLL	<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 _____