



**Maine Municipal  
Employees Health Trust**  
60 COMMUNITY DRIVE  
AUGUSTA, MAINE 04330-9486  
www.mmeht.org  
Fax 207-624-0166

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"/> Late Enrollee With Portability or Qualifying Event <input type="checkbox"/> Late Enrollee – No Portability or Qualifying Event		
<b>EMPLOYEE NAME ADDRESS &amp; TELEPHONE</b>	Employee Name _____	Date of Birth _____	Gender _____ <input type="checkbox"/> Male <input type="checkbox"/> Female
	Mailing Address _____		Social Security Number _____
	Town _____	State _____	Zip _____
<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 children between 19 and 26 years of age.		
	<b>Name (Last, First, MI)</b>	<b>Date of Birth</b>	<b>Gender</b>
	<input type="checkbox"/> Spouse or <input type="checkbox"/> DP Name (check one)	MO/DA/YR	M    F
	Child Name _____		
	Child Name _____		
<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, or a change in 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 will be subject to Eligibility and Enrollment provisions in the plan document which may include Late Enrollee provisions.
	<input type="checkbox"/> I elect not to enroll my dependents at this time and understand that if I apply at a future date, enrollment will be subject to Eligibility and Enrollment provisions in the plan document which may include Late Enrollee provisions.
	NAME (PRINT) _____ EMPLOYER _____
	SIGNATURE _____ DATE _____

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