



**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:	

### Health Application for Enrollment/Change

PLEASE PRINT

Areas printed in green apply to Point of Service (POS) election only.

<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)		
	Annual wages or salary	MMEHT Department Code		<input type="checkbox"/> New Group (initial enrollment) <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Portability or Qualifying Event		
<b>PLAN CHOICE</b>	<input type="checkbox"/> Indemnity <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> _____					
<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/DA/YR	<b>Gender</b> M F	<b>Social Security Number</b>	<b>Primary Care Physician (PCP)</b> (www.anthem.com)	<b>Current Patient?</b>
	Employee Name				PCP Full Name:	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:	Y <input type="checkbox"/> N <input type="checkbox"/>
					PCP ID	
					PCP Full Name:	Y <input type="checkbox"/> N <input type="checkbox"/>
				PCP ID		
				PCP Full Name:	Y <input type="checkbox"/> N <input type="checkbox"/>	
				PCP ID		
				PCP Full Name:	Y <input type="checkbox"/> N <input type="checkbox"/>	
				PCP ID		
				PCP Full Name:	Y <input type="checkbox"/> N <input type="checkbox"/>	
				PCP ID		
<b>ADDRESS &amp; TELEPHONE</b>	Mailing Address			Telephone 1		
	Town	State	Zip	Telephone 2		
<b>SIGNATURE</b>	<p>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.</p> <p>Employee Signature: _____ Date: _____</p>					
<b>ELECTION NOT TO ENROLL</b>	<input type="checkbox"/> I elect not to enroll in health 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