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

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

Health Application for Enrollment/Change

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

EMPLOYER SECTION

Employer

Date of Employment | Hours worked per week

Annual wages or salary | MMEHT Department Code

Enrollment Reason:
☐ New Hire ☐ Newly Eligible on _____ (date)
☐ New Group (initial enrollment)
☐ Open Enrollment
☐ Portability or Qualifying Event

PLAN CHOICE

☐ Indemnity ☐ PPO_____ (indicate plan) ☐ Point of Service_____ (indicate plan)

CHANGE STATUS

Type of change: ☐ Name change ☐ Add dependent ☐ Drop dependent ☐ Address change

Reason for change. **Date of change or event** _____

☐ Adoption
☐ Covered by other insurance
☐ Divorce
☐ Involuntary loss of coverage
☐ Birth
☐ Death
☐ Dissolution of Domestic Partnership
☐ Marriage
☐ Court order
☐ Discharge from the Military
☐ Entrance to the Military
☐ 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	Gender F	Social Security Number	Primary Care Physician (PCP) (www.anthem.com)	Current Patient?
Employee Name		☐	☐		PCP Full Name: PCP ID	Y ☐ N ☐
☐Spouse or ☐DP Name (check one)		☐	☐		PCP Full Name: PCP ID	Y ☐ N ☐
Child Name		☐	☐		PCP Full Name: PCP ID	Y ☐ N ☐
Child Name		☐	☐		PCP Full Name: PCP ID	Y ☐ N ☐
Child Name		☐	☐		PCP Full Name: PCP ID	Y ☐ N ☐

ADDRESS & TELEPHONE

Mailing Address | Telephone 1

Town | State | Zip | Telephone 2

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. 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: _____

ELECTION NOT TO ENROLL

☐ 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

Return Original Form to MMEHT. Please make a copy to retain for your records.