



**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

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) <input type="checkbox"/> New Group (initial enrollment) <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Portability or Qualifying Event	
	Annual wages or salary		MMEHT Department Code			
<b>PLAN CHOICE</b>	<input type="checkbox"/> Indemnity <input type="checkbox"/> PPO _____ (indicate plan) <input type="checkbox"/> Point of Service _____ (indicate plan)					
<b>EMPLOYEE NAME ADDRESS &amp; TELEPHONE</b>	Employee Name				Social Security Number	
	Mailing Address				Telephone 1	
	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> _____					
<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 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.					
	<b>Name (Last, First, MI)</b>	<b>Date of Birth MO/DA/YR</b>	<b>Gender M F</b>	<b>Social Security Number</b>	<b>Primary Care Physician (PCP) (www.anthem.com)</b>	<b>Current Patient?</b>
	Self				PCP Full Name:	Y <input type="checkbox"/> N <input type="checkbox"/>
	<input type="checkbox"/> Spouse or <input type="checkbox"/> DP Name (check one)				PCP Full Name:	Y <input type="checkbox"/> N <input type="checkbox"/>
	Child Name				PCP ID PCP Full Name:	Y <input type="checkbox"/> N <input type="checkbox"/>
	Child Name				PCP ID PCP Full Name:	Y <input type="checkbox"/> N <input type="checkbox"/>
	Child Name				PCP ID PCP Full Name:	Y <input type="checkbox"/> N <input type="checkbox"/>
<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. 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: _____	
<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