



**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:

**VSP VISION PLAN  
Application for Enrollment**

<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

**Employee: Complete this section only if you are enrolling in the Vision Plan coverage.**

**If you do not wish to enroll, please complete the "Election Not to Enroll" section below.**

<b>PLAN CHOICE</b>	I elect to be insured at <input type="checkbox"/> <b>Employee Only</b> <input type="checkbox"/> <b>Employee/Spouse</b> <input type="checkbox"/> <b>Employee/Child</b> <input type="checkbox"/> <b>Family</b> coverage and hereby authorize my employer to withhold from payroll the amount necessary to make coverage effective.			
<b>NAME, ADDRESS &amp; TELEPHONE</b>	Employee Name	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number
	Mailing Address			Telephone 1
	Town	State	Zip	Telephone 2

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>FAMILY INFORMATION (IF ELECTING FAMILY COVERAGE)</b>	<b>Name (Last, First, MI)</b>	<b>Date of Birth Month/Day/Year</b>	<b>Gender</b>	
			<b>Male</b>	<b>Female</b>
	<input type="checkbox"/> Spouse or <input type="checkbox"/> DP (check one)			
	Child			
	Child			
	Child			

<b>SIGNATURE</b>	<p>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.</p> <p>Employee Signature: _____ Date: _____</p>
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<b>ELECTION NOT TO ENROLL</b>	<input type="checkbox"/> I elect not to enroll in VSP Vision coverage at this time. I understand that if I choose to enroll at a later date, enrollment will only be available during the open enrollment period. NAME (print) _____ EMPLOYER _____ SIGNATURE _____ DATE _____
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**For questions, please contact the Health Trust at 207-623-8428 or (within Maine) 800-452-8786**