



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/Change

EMPLOYER SECTION	Employer _____	Enrollment Reason: <input type="checkbox"/> New Hire <input type="checkbox"/> Newly Eligible on _____ (date) <input type="checkbox"/> New Group (initial enrollment) <input type="checkbox"/> Open Enrollment
	Date of Employment _____ Hours worked per week _____	

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.

PLAN CHOICE	I elect to be insured at <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child <input type="checkbox"/> Family coverage and hereby authorize my employer to withhold from payroll the amount necessary to make coverage effective.			
NAME, ADDRESS & TELEPHONE	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.

CHANGE STATUS	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. Date of change or event _____ <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 _____

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

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. Employee Signature: _____ Date: _____
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ELECTION NOT TO ENROLL	<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 call the Health Trust at 207-621-2645 or (within Maine) 1-800-852-8300