MAINE MUNICIPAL
EMPLOYEES HEALTH TRUST
60 Community Drive | Augusta, ME 04330-9486
(207) 621-2645 or 1-800-852-8300 | www.mmeht.org

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

INCOME PROTECTION PLAN
ENROLLMENT/CHANGE FORM
PLEASE PRINT

1. EMPLOYER SECTION

NOT TO BE COMPLETED BY EMPLOYEE

Employer		**Enrollment Reason:**
Date of Employment	Hours worked per week	☐ New Hire ☐ Newly Eligible on (date & reason) _____ ☐ New Group (initial enrollment) ☐ Increase/Decrease Coverage ☐ Late Enrollee ☐ Employer Change-Dept/Union Change - not previously eligible to enroll in plan or at the same premium
Annual wages or salary	Department	

Is employee actively working as of the effective date of coverage, or available to work if it is not a regularly scheduled workday? ☐ Yes ☐ No

***Employer Signature**: _____ ***Title**: _____

CANNOT BE SIGNED BY THE EMPLOYEE ENROLLING IN COVERAGE

Employee: Complete section below only if you are enrolling in the Income Protection Plan coverage.
If you do not wish to enroll, please complete the "Election Not to Enroll" section below.

2. PLAN CHOICE

I elect to be insured at ☐ 40% ☐ 55% ☐ 70% of salary as a weekly benefit

3. NAME, ADDRESS & TELEPHONE

Employee Legal Name	Date of Birth	Gender ☐ Male ☐ Female ☐ Non-Binary	Social Security Number
Mailing Address			Home Phone: Cell Phone:
Town State Zip			Work Phone:

4. SIGNATURE

I am requesting coverage, or a change in coverage, for myself. 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 that the benefits I am applying for are subject to the terms and conditions stated in the applicable Health Trust Plan Document and that benefits will be coordinated with other insurance programs. I understand that I am subject to the Plan's subrogation rights and responsibilities, as defined by the Plan in the applicable Health Trust Plan Document and/or Summary Plan Description. Any dispute of claim will be resolved by the grievance procedures established in the applicable Health Trust Plan Document.

Employee Signature: _____ Date: _____

5. ELECTION NOT TO ENROLL

☐ I elect not to enroll in the Income Protection Plan during my new hire enrollment period. I understand I can elect to enroll at any time but will be subject to the evidence of insurability process and coverage may be denied.

NAME (print)_____ EMPLOYER _____

SIGNATURE _____ DATE _____

Email completed form to htbilling@memun.org or fax (207) 624-0166
For questions, please call the Billing & Enrollment Dept. at 207-621-2645 or (within Maine) 800-452-8786 EXT. 2585

PLEASE RETAIN A COPY FOR YOUR RECORDS