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
Status
Entered by:

MEDICAL PLAN APPLICATION ENROLLMENT/CHANGE FORM

PLEASE PRINT

1. EMPLOYER SECTION

Employer		**Enrollment Reason:**
Date of Employment	Elected Official (Yes or No) Yes No	☐ New Hire ☐ Newly Eligible on (date & reason)______________ ☐ New Group (initial enrollment) ☐ Open Enrollment ☐ Portability or Qualifying Event ☐ Employer Change-Dept/Union Change (not previously eligible)
Annual wages or salary	Hours worked per week	

2. PLAN CHOICE

☐ **Acadia (POS C)** ☐ **Baxter (POS 200)** ☐ **Katahdin (PPO 500)**
☐ **Moosehead (PPO 1500)** ☐ **Pemaquid (PPO 2500)**

If you are enrolling in a medical plan, please also complete the MMEHT life enrollment form for submission.

3. EMPLOYEE NAME ADDRESS & TELEPHONE

Employee Legal Name	Social Security Number
Mailing Address	Home Phone: Cell Phone:
Town State Zip	Work Phone:

4. CHANGE STATUS

Type of change: ☐ Address Change ☐ Name Change – provide previous name: ______________
☐ Add dependent(s) listed below in section 5 ☐ Drop dependent(s) listed below in section 5

Reason for change: **Date of change or event:** ______________

☐ Adoption ☐ Birth (if grandchild see below*) ☐ Court order
☐ Covered by other insurance ☐ Death ☐ Discharge from the Military
☐ Divorce ☐ Dissolution of Domestic Partnership ☐ Entrance to the Military
☐ Involuntary loss of coverage ☐ Marriage ☐ Other ______________

☐ * Grandchild - Coverage for 31 days from birth only. Please contact the Health Trust with questions.

5. MEMBER AND FAMILY INFORMATION

You may apply to cover your legal spouse, domestic partner (DP) (IF your employer offers this benefit and the Trust receives a completed MMEHT Domestic Partner Affidavit form verifying qualification) and children between birth and 26 years of age.

Legal Name (Last, First, MI)	Date of Birth MM/DD/YR	Gender M	F	Non-Binary	Social Security Number
Self					**Provided Above**
Spouse or Domestic Partner					
Child					
Child					
Child					

6. SIGNATURE

I am requesting coverage for myself, and all dependents listed, including any type of change selected in the Change Status section as indicated above. 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 benefit 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: ______________

7. ELECTION NOT TO ENROLL

☐ I elect not to enroll in health coverage during my new hire enrollment period. I understand I may choose to elect coverage later during open enrollment or with a qualifying event.

NAME (PRINT): ______________ EMPLOYER: ______________

SIGNATURE: ______________ DATE: ______________

Email completed form to htbilling@memun.org or via fax to (207) 624-0166
For questions, please call the Billing & Enrollment Department at (207) 621-2645 or (within Maine (800) 452-8786 EXT. 2585
PLEASE RETAIN A COPY FOR YOUR RECORDS