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

Standard Insurance Co.
Group Policy NO. 648982

MMEHT LIFE INSURANCE PLAN
ENROLLMENT/CHANGE FORM
PLEASE PRINT

Employer:	**Date of Hire:**	**Annual Salary:**

Beneficiary Change ☐	**Address Change** ☐	**Name Change** ☐ **Previous Name:**	**Benefit Change** ☐

Employee Legal Name: _____ Soc. Sec. #: _____

Employee Address: _____

Phone (H/C)_____ (W)_____ Gender ____ Marital Status ____ Date of Birth _____

I would like to enroll in the following Life Insurance coverage(s): May require evidence of insurability

Type of Coverage – Check coverage and level option(s) desired only if offered by your employer

Basic Life ☐
Life No Medical ☐
Supplemental Life ☐ Please enroll me for: ☐ 1x ☐ 2x ☐ 3x salary ☐ Drop
Dependent Life ☐ Please enroll me in: ☐ Option A ☐ Option B ☐ Drop

Dependent Information: Complete only if enrolling in Dependent Life

Name	**Date of Birth**	**Relationship**

Beneficiary Designation: Please designate each name as Primary (P) or Contingent (C) in last column

Name	**Relationship**	**Address**	**Percentage**	**P or C**

I hereby apply for life insurance to which I am entitled or to which I may become entitled under the terms of the group policy or policies issued to the Maine Municipal Employees Health Trust. If I do not elect the health coverage, I understand that I have the option to enroll in Life No Medical for a monthly premium.

Enrolling in Life Insurance: Signature_____ Date: _____

I understand by not electing to enroll in life insurance during my new hire period, I can elect to enroll at any time, but will be subject to the evidence of insurability process and coverage may be denied.

Not Enrolling in Life: Signature _____ Date: _____

PLEASE READ IMPORTANT INFORMATION ON THE NEXT PAGE
Email completed form to htbilling@memun.org or Fax (207) 624-0166
PLEASE RETAIN A COPY FOR YOUR RECORDS

DEFINITIONS: **Primary Beneficiary** – The person or persons you want to receive the life insurance benefits if you die.
Contingent Beneficiary –The person or persons you want to receive the life insurance benefit if no Primary Beneficiary is alive on the date of your death.

Note:
If more than one primary beneficiary is designated, settlement will be made in equal shares to the designated beneficiaries who are then still living, unless their shares are specified. If there is no named beneficiary or if no beneficiary survives, settlement will be made in the following order: surviving spouse; equal shares to surviving children; equal shares to surviving parents; equal shares to surviving siblings; your Estate.

A member cannot be covered as both an employee/retiree under Basic or Supplemental coverage and also as a dependent under Dependent Life coverage.

IMPORTANT NOTICE:
Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive, or misleading facts or information when filing a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is guilty of a crime, and may be prosecuted and punished under state law. Penalties may include fines, civil damages, and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

General Disclosure:
Group Life Insurance coverage is issued by Standard Insurance Company. The phone number for Life Claims is: 1-800-628-8600. Please refer to the Booklet-Certificate, which is made a part of the Group Contract, for all plan details, including any exclusions, limitations and restrictions which may apply. If there is a discrepancy between this document and the Booklet-Certificate/Group Contract issued by Standard Insurance Company, the terms of the Group Contract will govern.

Please Return Completed Form to:

htbilling@memun.org or fax (207) 624-0166

or mail to:
Maine Municipal Employees Health Trust
60 Community Drive
Augusta, Maine 04330

For questions, please call the Billing & Enrollment Dept. at 207-621-2645 or (within Maine) 800-452-8786 EXT. 2585