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:

DENTAL PLAN APPLICATION
ENROLLMENT/CHANGE FORM
Please Print

EMPLOYER SECTION	Employer		Date of Employment	Hours worked per week

2. ENROLLMENT REASON

☐ New Hire ☐ Newly Eligible on (date & reason) _____ ☐ New Group (initial enrollment)

☐ Late Enrollee with Portability or Qualifying Event ☐ Open Enrollment

3. EMPLOYEE NAME ADDRESS & TELEPHONE

Employee Legal Name	Date of Birth	Gender	Social Security Number
		☐ Male ☐ Female ☐ Non-Binary	
Mailing Address			Phone (home/cell)
Town	State	Zip	Phone (work)

4. CHANGE STATUS

Type of change: ☐ Address change ☐ Name change - provide previous name: _____

☐ Add dependent(s) listed in section 5 below ☐ Drop dependent(s) listed in section 5 below

Reason for change: Date of change or event _____

☐ Adoption	☐ Birth	☐ 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 _____

5. MEMBER AND FAMILY INFORMATION

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 children between birth and 26 years of age.

Name (Last, First, MI)	Date of Birth MO/DA/YR	Gender M	Gender F	Gender Non-Binary	Social Security Number
☐ Spouse or ☐ Domestic Partner					
Child					
Child					
Child					

6. OTHER COVERAGE

Is your spouse employed? ☐ Yes ☐ No	Do you or your dependents have other dental insurance? ☐ Yes ☐ No	
If yes, name of insurance	Certificate Number	Policyholder
Name(s) of covered individual(s)	If coverage is recently terminated, state reason and date of loss.	

7. SIGNATURE

I am requesting coverage, or a change in 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's Signature: _____ Date: _____

8. ELECTION NOT TO ENROLL

☐ I elect not to enroll in dental coverage at this time. I understand that if I choose to enroll at a later date, enrollment may be available only during the open enrollment period, unless portability or special enrollment provisions apply.

NAME (PRINT) _____ EMPLOYER _____

SIGNATURE _____ DATE _____

Email completed form to htbilling@memun.org or via fax at (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