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 for Enrollment/Change

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 - Late Enrollee – No Portability or Qualifying Event			
3. EMPLOYEE NAME ADDRESS & TELEPHONE	Employee Legal Name	Date of Birth	Gender ☐ Male ☐ Female	Social Security Number
	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. 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	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 at this time. I understand that if I wish to enroll in Dental coverage at a future date, enrollment will be subject to Eligibility and Enrollment provisions in the plan document.

☐ I elect not to enroll my dependents at this time. I understand that if I wish to enroll my dependents in Dental coverage at a future date, enrollment will be subject to Eligibility and Enrollment provisions in the plan document.

NAME (PRINT) _____ EMPLOYER _____

SIGNATURE _____ DATE _____

For questions, please call the Health Trust at 207-621-2645 or (within Maine) 800-852-8300 FAX (207) 624-0166

Return form to MMEHT. Please make a copy to retain for your records.