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:

Medical Plan Application for Enrollment/Change

PLEASE PRINT

1. EMPLOYER SECTION

Employer

Date of Employment

Annual wages or salary | Hours worked per week

Enrollment Reason:

- ☐ New Hire
- ☐ Newly Eligible on (date & reason) _____
- ☐ New Group (initial enrollment)
- ☐ Open Enrollment
- ☐ Portability or Qualifying Event
- ☐ Employer Change-Dept/Union Change_____

2. PLAN CHOICE

☐ PPO_____ (indicate plan) ☐ Point of Service_____ (indicate plan)

3. EMPLOYEE NAME ADDRESS & TELEPHONE

Employee Legal Name | Social Security Number

Mailing Address | Phone (home/cell)

Town State Zip | Phone (work)

4. CHANGE STATUS

Type of change: ☐ Name change ☐ Add dependent (s) listed below ☐ Drop dependent (s) listed below ☐ Address change

Previous Name (if name change) _____

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

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

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

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.

Legal Name (Last, First, MI)	Date of Birth MO/DA/YR	Gender M	Gender F	Social Security Number	Primary Care Physician (PCP) (www.anthem.com)	Current Patient?
Self				Provided Above	PCP Name/Address(city/town)	Y ☐ N ☐
☐Spouse or ☐Domestic Partner					PCP Name/Address(city/town)	Y ☐ N ☐
Child					PCP Name/Address(city/town)	Y ☐ N ☐
Child					PCP Name/Address(city/town)	Y ☐ N ☐
Child					PCP Name/Address(city/town)	Y ☐ N ☐

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 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 _____

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