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:	

INCOME PROTECTION PLAN

Application for Enrollment

(207) 623-8428 or (within Maine) 800-452-8786 Fax: (207) 624-0166

EMPLOYER SECTION

Employer:		**Enrollment Reason:**	
		☐	New Hire
		☐	Newly Eligible on (date & reason):
Date of Employment:	Hours worked per week:		
		☐	New Group (initial enrollment)
		☐	Increase/Decrease Coverage
Annual wages or salary:	MMEHT Department Code:	☐	Late Enrollee
		☐	Employer Change-Dept./Union Change

Is employee actively working as of the effective date of coverage, or available to work if it is not a regularly scheduled work day? ☐ Yes ☐ No

Employer Signature: Title:

Employee: Complete this section <u>only</u> if you are enrolling in the Income Protection Plan coverage.
If you do not wish to enroll, please complete the "Election Not to Enroll" section below.

PLAN CHOICE

I elect to be insured at ☐ **40%** ☐ **55%** ☐ **70%** of salary as a weekly benefit and hereby authorize my employer to withhold from payroll the amount necessary to make coverage effective.

NAME, ADDRESS & TELEPHONE

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

SIGNATURE

I am requesting coverage, or a change in coverage, for myself. 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 that the benefits I am applying for are subject to the terms and conditions stated in the applicable Health Trust Plan Document and that benefits will be coordinated with other insurance programs. I understand that I am subject to the Plan's subrogation rights and responsibilities, as defined by the Plan in the applicable Health Trust Plan Document and/or Summary Plan Description. Any dispute of claim will be resolved by the grievance procedures established in the applicable Health Trust Plan Document.

Employee Signature: **Date:**

ELECTION NOT TO ENROLL

☐ I elect not to enroll in Income Protection coverage at this time, and understand that if I apply at a future date, enrollment may not be permissible without evidence of good health**.**

NAME (print): EMPLOYER:

SIGNATURE: DATE:

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