Maine Municipal
Employees Health Trust
www.mmeht.org

TERMINATION NOTIFICATION FORM

Email completed form to htbilling@memun.org or Fax: (207) 624-0166

DEDUCTING PREMIUM FROM CURRENT BILL **PLEASE CREDIT OUR NEXT BILL**

EMPLOYEE'S INFORMATION (To Be Completed By Employer)						
Employer:		Employee Participated in LD1021:		YES		NO
Employee's Legal Name:						
Alternate ID# (from the bill):						
Current Mailing Address:						
City/State/Zip:						

	REASON FOR COVERAGE TERMINATION (Please Check Appropriate Box) & Specify Date Requested		
	Terminated Employment	Last Date Worked:	
	Terminated Employment During Leave of Absence	Last Date Considered Employee:	
	Retired Collecting MEPERS Thru This Employer	Last Date Worked:	
	Retired No MEPERS (please include Retiree Eligibility Form from mmeht.org)	Last Date Worked:	
	Cancelled by Employer for nonpayment of premiums during a leave of absence:	Cov Term Date:	
	Reduction of Hours-no longer eligible for coverage	Last Date as Full Time Employee:	
	Military Leave	Last Date Worked:	
	Death of Employee	Date of Death:	
	Employee Still Working-Chooses to Cancel Coverage (Check all that apply below)	Cov Term Date:	

	Health		*Life*		*Dental*		*Vision*		*IPP*		*LTD*

If cancelling health, life coverage may continue at a cost of .30 per $1,000 of life volume per month

Printed Name of Person completing form

Signature of Person completing (cannot be employee above)

FOR MMEHT USE ONLY					
IPP/LTD Coverage Term Date:		Term Date For All Other Plans:			
Subgroup:	Health Plan:	Status:	Status:	Status:	
Name		Health Eff Date	Dental Eff Date	Vision Eff Date	Life Vol.
Mbr:					Basic:
Spouse:					
Dep1:					Supp:
Dep2:					
Dep3:					Spouse:
Dep4:					
Dep5:					Dep:
Dep6:					