Maine Municipal
Employees Health Trust
60 COMMUNITY DRIVE
AUGUSTA, MAINE 04330-9486
www.mmeht.org

VSP Vision care for life

MMEHT OFFICE USE ONLY
Subgroup No.
Effective Date
Status
Entered by:

VSP VISION PLAN

Application for Enrollment/Change

PLEASE PRINT

1. EMPLOYER SECTION	Employer		**Enrollment Reason:** ☐ New Hire ☐ Newly Eligible on (date & reason)_____ ☐ New Group (initial enrollment) ☐ Open Enrollment ☐ Portability/Qualifying Event
	Date of Employment	Hours worked per week	

Employee: Complete this section <u>only</u> if you are enrolling in the Vision Plan coverage.

If you do not wish to enroll, please complete the "Election Not to Enroll" section below.

2. PLAN CHOICE	**I elect to be insured at ☐ Employee Only ☐ Employee/Spouse ☐ Employee/Child ☐ Family** coverage and hereby authorize my employer to withhold from payroll the amount necessary to make coverage effective.			
3. 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)

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.

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 (IF ELECTING FAMILY COVERAGE)

Name (Last, First, MI)	Date of Birth Month/Day/Year	Gender	
		Male	Female
☐Spouse or ☐Domestic Partner			
Child			
Child			
Child			

6. SIGNATURE

I am requesting 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 Signature: _____ Date: _____

7. ELECTION NOT TO ENROLL

☐ I elect not to enroll in VSP Vision coverage at this time. I understand that if I choose to enroll at a later date, enrollment will only be available during the open enrollment period.

NAME (print) _____ EMPLOYER _____

SIGNATURE _____ DATE _____

For questions, please call the Health Trust at 207-621-2645 or (within Maine) 1-800-852-8300 FAX (207) 624-0166