



# MAINE MUNICIPAL EMPLOYEES HEALTH TRUST

60 Community Drive | Augusta, ME 04330-9486  
(207) 621-2645 or 1-800-852-8300 | www.mmeht.org

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

## MEDICAL PLAN APPLICATION ENROLLMENT/CHANGE FORM PLEASE PRINT

<b>1. EMPLOYER SECTION</b>	Employer	<b>Enrollment Reason:</b>				
	Date of Employment	Elected Official (Yes or No)	<input type="checkbox"/> New Hire <input type="checkbox"/> Newly Eligible on (date & reason) _____ <input type="checkbox"/> New Group (initial enrollment) <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Portability or Qualifying Event <input type="checkbox"/> Employer Change-Dept/Union Change (not previously eligible)			
	Annual wages or salary	Hours worked per week				
<b>2. PLAN CHOICE</b>	<input type="checkbox"/> PPO _____ (indicate plan)		Point of Service _____ (indicate plan)			
<b>If you are enrolling in a medical plan, please also complete the MMEHT life enrollment form for submission.</b>						
<b>3. EMPLOYEE NAME ADDRESS &amp; TELEPHONE</b>	Employee Legal Name			Social Security Number		
	Mailing Address			Home Phone:		
	Town	State	Zip	Cell Phone:		
<b>4. CHANGE STATUS</b>	Type of change: <input type="checkbox"/> Address Change <input type="checkbox"/> Name Change – provide previous name: _____					
	<input type="checkbox"/> Add dependent(s) listed below in section 5 <input type="checkbox"/> Drop dependent(s) listed below in section 5					
<b>5. MEMBER AND FAMILY INFORMATION</b>	<b>Reason for change:</b>		<b>Date of change or event:</b> _____			
	<input type="checkbox"/> Adoption <input type="checkbox"/> Covered by other insurance <input type="checkbox"/> Divorce <input type="checkbox"/> Involuntary loss of coverage	<input type="checkbox"/> Birth (if grandchild see below*) <input type="checkbox"/> Death <input type="checkbox"/> Dissolution of Domestic Partnership <input type="checkbox"/> Marriage	<input type="checkbox"/> Court order <input type="checkbox"/> Discharge from the Military <input type="checkbox"/> Entrance to the Military <input type="checkbox"/> Other _____	<input type="checkbox"/> * Grandchild - Coverage for 31 days from birth only. Please contact the Health Trust with questions.		
<b>5. MEMBER AND FAMILY INFORMATION</b>	You may apply to cover your legal spouse, domestic partner (DP) (IF your employer offers this benefit and the Trust receives a completed MMEHT Domestic Partner Affidavit form verifying qualification) and children between birth and 26 years of age.					
	<b>Legal Name (Last, First, MI)</b>	<b>Date of Birth MM/DD/YR</b>	<b>Gender M F Non-Binary</b>	<b>Social Security Number</b>	<b>Primary Care Physician-PCP (www.anthem.com) POS Plans ONLY</b>	<b>Current Patient?</b>
	Self			Provided Above	PCP Name/Address(city/town)	Y <input type="checkbox"/> N <input type="checkbox"/>
	<input type="checkbox"/> Spouse or <input type="checkbox"/> Domestic Partner				PCP Name/Address(city/town)	Y <input type="checkbox"/> N <input type="checkbox"/>
	Child				PCP Name/Address(city/town)	Y <input type="checkbox"/> N <input type="checkbox"/>
	Child				PCP Name/Address(city/town)	Y <input type="checkbox"/> N <input type="checkbox"/>
<b>6. SIGNATURE</b>	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: _____					
<b>7. ELECTION NOT TO ENROLL</b>	<input type="checkbox"/> I elect not to enroll in health coverage during my new hire enrollment period. I understand I may choose to elect coverage later during open enrollment or with a qualifying event.					
NAME (PRINT): _____ EMPLOYER: _____						
SIGNATURE: _____ DATE: _____						

Email completed form to [htbilling@memun.org](mailto:htbilling@memun.org) or via fax to (207) 624-0166  
For questions, please call the Billing & Enrollment Department at (207) 621-2645 or (within Maine) (800) 452-8786 EXT. 2585  
PLEASE RETAIN A COPY FOR YOUR RECORDS