



**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 _____
Entered by: _____

**INCOME PROTECTION PLAN
ENROLLMENT/CHANGE FORM
PLEASE PRINT**

1. EMPLOYER SECTION NOT TO BE COMPLETED BY EMPLOYEE	Employer _____		Enrollment Reason: <input type="checkbox"/> New Hire <input type="checkbox"/> Newly Eligible on (date & reason) _____ <input type="checkbox"/> New Group (initial enrollment) <input type="checkbox"/> Increase/Decrease Coverage <input type="checkbox"/> Late Enrollee <input type="checkbox"/> Employer Change-Dept/Union Change - not previously eligible to enroll in plan or at the same premium
	Date of Employment _____	Hours worked per week _____	
	Annual wages or salary _____	Department _____	
	Is employee actively working as of the effective date of coverage, or available to work if it is not a regularly scheduled workday? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	*Employer Signature: _____ *Title: _____		
CANNOT BE SIGNED BY THE EMPLOYEE ENROLLING IN COVERAGE			

**Employee: Complete section below only 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.**

2. PLAN CHOICE	I elect to be insured at <input type="checkbox"/> 40% <input type="checkbox"/> 55% <input type="checkbox"/> 70% of salary as a weekly benefit			
3. NAME, ADDRESS & TELEPHONE	Employee Legal Name _____	Date of Birth _____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary	Social Security Number _____
	Mailing Address _____			Home Phone: _____ Cell Phone: _____
	Town _____	State _____	Zip _____	Work Phone: _____
4. SIGNATURE	<p>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.</p> <p>Employee Signature: _____ Date: _____</p>			
5. ELECTION NOT TO ENROLL	<input type="checkbox"/> I elect not to enroll in the Income Protection Plan during my new hire enrollment period. I understand I can elect to enroll at any time but will be subject to the evidence of insurability process and coverage may be denied.			
	NAME (print) _____	EMPLOYER _____		
	SIGNATURE _____	DATE _____		

Email completed form to htbilling@memun.org or fax (207) 624-0166
For questions, please call the Billing & Enrollment Dept. at 207-621-2645 or (within Maine) 800-452-8786 EXT. 2585

PLEASE RETAIN A COPY FOR YOUR RECORDS