



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:	

VISION PLAN APPLICATION ENROLLMENT/CHANGE FORM PLEASE PRINT

1. EMPLOYER SECTION	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"/> Open Enrollment <input type="checkbox"/> Portability/Qualifying Event			
	Date of Employment _____	Hours worked per week _____				
2. PLAN CHOICE	I elect to be insured at the <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child <input type="checkbox"/> Family level of 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 <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary	Social Security Number _____		
	Mailing Address _____			Home Phone: _____		
	Town _____	State _____	Zip _____	Cell Phone: _____ Work Phone: _____		
4. CHANGE STATUS	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					
	Reason for change: Date of change or event _____ <input type="checkbox"/> Adoption <input type="checkbox"/> Birth <input type="checkbox"/> Court order <input type="checkbox"/> Covered by other insurance <input type="checkbox"/> Death <input type="checkbox"/> Discharge from the Military <input type="checkbox"/> Divorce <input type="checkbox"/> Dissolution of Domestic Partnership <input type="checkbox"/> Entrance to the Military <input type="checkbox"/> Involuntary loss of coverage <input type="checkbox"/> Marriage <input type="checkbox"/> Other _____					
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, verifying qualification) and children between birth and 26 years of age.						
5. FAMILY INFORMATION (IF ELECTING FAMILY COVERAGE)	Name (Last, First, MI)		Date of Birth	Gender		
	<input type="checkbox"/> Spouse or <input type="checkbox"/> Domestic Partner		Month/Day/Year	Male	Female	Non-Binary
	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	<input type="checkbox"/> I elect not to enroll in VSP Vision 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 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