



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

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

Dental Plan Application for Enrollment/Change
PLEASE PRINT

EMPLOYER SECTION	Employer _____	Date of Employment _____	Hours worked per week _____
ENROLLMENT REASON	<input type="checkbox"/> New Hire <input type="checkbox"/> Newly Eligible on _____ (date) <input type="checkbox"/> New Group (initial enrollment) <input type="checkbox"/> Late Enrollee With Portability or Qualifying Event <input type="checkbox"/> Open Enrollment - Late Enrollee – No Portability or Qualifying Event		
EMPLOYEE NAME ADDRESS & TELEPHONE	Employee Name _____	Date of Birth _____	Gender _____ <input type="checkbox"/> Male <input type="checkbox"/> Female
	Mailing Address _____		Social Security Number _____
	Town _____	State _____	Zip _____
CHANGE STATUS	Type of change: <input type="checkbox"/> Name change <input type="checkbox"/> Add dependent(s) listed below <input type="checkbox"/> Drop dependent(s) listed below <input type="checkbox"/> Address change <input type="checkbox"/> Previous Name (if name change) _____		
	Reason for change. <input type="checkbox"/> Adoption <input type="checkbox"/> Birth <input type="checkbox"/> Covered by other insurance <input type="checkbox"/> Death <input type="checkbox"/> Divorce <input type="checkbox"/> Dissolution of Domestic Partnership <input type="checkbox"/> Involuntary loss of coverage <input type="checkbox"/> Marriage		Date of change or event _____ <input type="checkbox"/> Court order <input type="checkbox"/> Discharge from the Military <input type="checkbox"/> Entrance to the Military <input type="checkbox"/> Other _____
FAMILY INFORMATION	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.		
	Name (Last, First, MI)		Date of Birth
	<input type="checkbox"/> Spouse or <input type="checkbox"/> DP Name (check one)		MO/DA/YR
	Child Name _____		Gender
	Child Name _____		M F
OTHER COVERAGE	Is your spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you or your dependents have other dental insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, name of insurance _____	Certificate Number _____	Policyholder _____
	Name(s) of covered individual(s) _____	If coverage is recently terminated, state reason and date of loss.	
SIGNATURE	I am requesting coverage, or a change in 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's Signature: _____ Date: _____		

ELECTION NOT TO ENROLL	<input type="checkbox"/> I elect not to enroll at this time. I understand that if I wish to enroll in Dental coverage at a future date, enrollment will be subject to Eligibility and Enrollment provisions in the plan document.
	<input type="checkbox"/> I elect not to enroll my dependents at this time. I understand that if I wish to enroll my dependents in Dental coverage at a future date, enrollment will be subject to Eligibility and Enrollment provisions in the plan document.
	NAME (PRINT) _____ EMPLOYER _____
	SIGNATURE _____ DATE _____

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