



**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:

### Medical Plan Application for Enrollment/Change

PLEASE PRINT

<b>1. EMPLOYER SECTION</b>	Employer		<b>Enrollment Reason:</b> <input type="checkbox"/> New Hire <input type="checkbox"/> Newly Eligible on _____ (date) <input type="checkbox"/> New Group (initial enrollment) <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Portability or Qualifying Event <input type="checkbox"/> Employer Change			
	Date of Employment	Hours worked per week				
	Annual wages or salary	MMEHT Department Code				
<b>2. PLAN CHOICE</b>	<input type="checkbox"/> PPO _____ (indicate plan) <input type="checkbox"/> Point of Service _____ (indicate plan)					
<b>3. CHANGE STATUS</b>	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					
	Previous Name (if name change) _____ Reason for change. <span style="float: right;">Date of change or event _____</span> <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 _____					
<b>4. FAMILY INFORMATION</b>	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.					
	<b>Name (Last, First, MI)</b>	<b>Date of Birth MO/DA/YR</b>	<b>Gender M F</b>	<b>Social Security Number</b>	<b>Primary Care Physician (PCP) (www.anthem.com)</b>	<b>Current Patient?</b>
	Employee Name				PCP Full Name:	Y <input type="checkbox"/> N <input type="checkbox"/>
	<input type="checkbox"/> Spouse or <input type="checkbox"/> DP Name (check one)				PCP ID	
					PCP Full Name:	Y <input type="checkbox"/> N <input type="checkbox"/>
	Child Name				PCP ID	
					PCP Full Name:	Y <input type="checkbox"/> N <input type="checkbox"/>
Child Name				PCP ID		
				PCP Full Name:	Y <input type="checkbox"/> N <input type="checkbox"/>	
Child Name				PCP ID		
				PCP Full Name:	Y <input type="checkbox"/> N <input type="checkbox"/>	
<b>5. ADDRESS &amp; TELEPHONE</b>	Mailing Address			Telephone 1		
	Town	State	Zip	Telephone 2		
<b>6. SIGNATURE</b>	I am requesting coverage for me 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 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. 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 medical coverage at this time. I understand that if I choose to enroll at a later date, enrollment may be available only during the open enrollment period, unless portability or special enrollment provisions apply.					
	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