



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:	

**INCOME PROTECTION PLAN**  
**Application for Enrollment**  
 207-623-8428 or (within Maine) 800-452-8786 Fax: (207) 624-0166

<b>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"/> Increase/Decrease Coverage <input type="checkbox"/> Late Enrollee
	Date of Employment	Hours worked per week	
	Annual wages or salary	MMEHT Department Code	
	Is employee actively working as of the effective date of coverage, or available to work if it is not a regularly scheduled work day? <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>		
	Employer Signature: _____ Title: _____		

**Employee: Complete this section 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.**

<b>PLAN CHOICE</b>	I elect to be insured at <input type="checkbox"/> 40% <input type="checkbox"/> 55% <input type="checkbox"/> 70% of salary as a weekly benefit and hereby authorize my employer to withhold from payroll the amount necessary to make coverage effective.			
<b>NAME, ADDRESS &amp; TELEPHONE</b>	Employee Name	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number
	Mailing Address			Telephone 1
	Town	State	Zip	Telephone 2
<b>SIGNATURE</b>	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 all benefits are subject to conditions stated in the Plan Document.  Employee Signature: _____ Date: _____			

<b>ELECTION NOT TO ENROLL</b>	<input type="checkbox"/> I elect not to enroll in Income Protection coverage at this time, and understand that if I apply at a future date, enrollment may not be permissible without evidence of good health.		
	NAME (print) _____	EMPLOYER _____	
	SIGNATURE _____	DATE _____	