



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

Standard Insurance Company  
 Group Policy No. 648982

**MMEHT LIFE PLAN  
 EMPLOYEE CHANGE FORM**

1. TYPE OF CHANGE	Beneficiary Change <input type="checkbox"/>	Name Change <input type="checkbox"/>	Address Change <input type="checkbox"/>	Benefit Change <input type="checkbox"/>
	Previous Name: _____			

2. EMPLOYER SECTION	Employer: _____	Date of Hire: _____	Annual Salary: _____
			\$ _____

3. EMPLOYEE SECTION	Employee Name: _____ Soc. Sec. #: _____	
	Employee Address: _____	
	Phone (H): _____ (W): _____	Gender: _____ Marital Status: _____ Date of Birth: _____

4. PLAN OPTIONS	<b>I would like to change my Life Insurance coverage(s) as specified below (you may only select coverage options offered by your employer):</b>			
	<u>Type of Coverage</u>	<u>Add</u>	<u>Drop</u>	<u>Level</u>
	Basic Life	<input type="checkbox"/>	<input type="checkbox"/>	N/A
	Supplemental Life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 1x salary <input type="checkbox"/> 2x salary* <input type="checkbox"/> 3x salary*
	Dependent Life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Option A <input type="checkbox"/> Option B    * Requires Evidence of Insurability
	Specify Change: _____			

**NOTE: PLEASE DESIGNATE EACH NAME AS PRIMARY (P) OR CONTINGENT (C) IN LAST COLUMN**

5. BENEFICIARY DESIGNATION	Name	Relationship	Address	Percentage	P or C

**NOTE: COMPLETE ONLY IF ENROLLING IN DEPENDENT LIFE**

6. DEPENDENT INFORMATION	Name	Date of Birth	Relationship

7. AUTHORIZED SIGNATURE	I hereby apply for life insurance to which I am entitled or to which I may become entitled under the terms of the group policy or policies issued to the Maine Municipal Employees Health Trust. I authorize the deduction from my earnings of any contribution I am required to make toward the cost of this insurance.	
	SIGNATURE: _____	DATE: _____

**PLEASE READ IMPORTANT INFORMATION ON THE NEXT PAGE**

**DEFINITIONS:**     **Primary Beneficiary** – The person or persons you want to receive the life insurance benefits if you die.  
                          **Contingent Beneficiary** –The person or persons you want to receive the life insurance benefit if no Primary Beneficiary is alive on the date of your death.

**Note:**

If more than one primary beneficiary is designated, settlement will be made in equal shares to the designated beneficiaries who are then still living, unless their shares are specified. If there is no named beneficiary or if no beneficiary survives, settlement will be made in the following order: surviving spouse; equal shares to surviving children; equal shares to surviving parents; equal shares to surviving siblings; your Estate.

**IMPORTANT NOTICE:**

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive, or misleading facts or information when filing a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is guilty of a crime, and may be prosecuted and punished under state law. Penalties may include fines, civil damages, and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

**General Disclosure:**

Group Life Insurance coverage is issued by Standard Insurance Company. The telephone number for Life Claims is: 1-800-628-8600. Please refer to the Booklet-Certificate, which is made a part of the Group Contract, for all plan details, including any exclusions, limitations and restrictions which may apply. If there is a discrepancy between this document and the Booklet-Certificate/Group Contract issued by Standard Insurance Company, the terms of the Group Contract will govern.

**Please Mail Completed Form to:**

Maine Municipal Employees Health Trust  
60 Community Drive  
Augusta, Maine 04330

(207) 621-2645

1-800-852-8300 (within Maine) Fax (207) 624-0166