



**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:	

**VSP VISION PLAN**  
**Application for Enrollment/Change**  
**PLEASE PRINT**

<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"/> Open Enrollment <input type="checkbox"/> Portability/Qualifying Event
	Date of Employment	Hours worked per week	

**Employee: Complete this section only if you are enrolling in the Vision 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"/> <b>Employee Only</b> <input type="checkbox"/> <b>Employee/Spouse</b> <input type="checkbox"/> <b>Employee/Child</b> <input type="checkbox"/> <b>Family</b> coverage 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

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>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 <input type="checkbox"/> Previous Name (if name change) _____			
	Reason for change. <input type="checkbox"/> Adoption <input type="checkbox"/> Covered by other insurance <input type="checkbox"/> Divorce <input type="checkbox"/> Involuntary loss of coverage		Date of change or event _____ <input type="checkbox"/> Birth <input type="checkbox"/> Death <input type="checkbox"/> Dissolution of Domestic Partnership <input type="checkbox"/> Marriage <input type="checkbox"/> Court order <input type="checkbox"/> Discharge from the Military <input type="checkbox"/> Entrance to the Military <input type="checkbox"/> Other _____	

<b>FAMILY INFORMATION (IF ELECTING FAMILY COVERAGE)</b>	Name (Last, First, MI)	Date of Birth Month/Day/Year	Gender	
			Male	Female
<input type="checkbox"/> Spouse or <input type="checkbox"/> DP (check one)				
Child				
Child				
Child				

<b>SIGNATURE</b>	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: _____

<b>ELECTION NOT TO ENROLL</b>	<input type="checkbox"/> I elect not to enroll in VSP Vision coverage at this time. I understand that if I choose to enroll at a later date, enrollment will only be available during the open enrollment period.	
	NAME (print) _____	EMPLOYER _____
	SIGNATURE _____	DATE _____

**For questions, please call the Health Trust at 207-621-2645 or (within Maine) 1-800-852-8300 FAX (207) 624-0166**