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
ENROLLMENT/CHANGE FORM

Please Print

EMPLOYER SECTION

Employer		Enrollment Reason:
Date of Employment	Hours worked per week	☐ New Hire ☐ Newly Eligible on (date & reason) ______________ ☐ New Group (initial enrollment)
Annual wages or salary	MMEHT Department Code	☐ Increase/Decrease Coverage ☐ Late Enrollee ☐ Employer Change-Dept/Union Change__________

Is employee actively working as of the effective date of coverage, or available to work if it is not a regularly scheduled workday? ☐ Yes ☐ No

***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.

PLAN CHOICE

I elect to be insured at ☐ 40% ☐ 55% ☐ 70% of salary as a weekly benefit and hereby authorize my employer to withhold from payroll the amount necessary to make coverage effective.

NAME, ADDRESS & TELEPHONE

Employee Legal Name	Date of Birth	Gender ☐ Male ☐ Female ☐ Non-Binary	Social Security Number
Mailing Address			Phone (home/cell)
Town State Zip			Phone (work)

SIGNATURE

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 that the benefits I am applying for are subject to the terms and conditions stated in the applicable Health Trust Plan Document and that benefits will be coordinated with other insurance programs. I understand that I am subject to the Plan's subrogation rights and responsibilities, as defined by the Plan in the applicable Health Trust Plan Document and/or Summary Plan Description. Any dispute of claim will be resolved by the grievance procedures established in the applicable Health Trust Plan Document.

Employee Signature: ______________________________ Date: ______________________________

ELECTION NOT TO ENROLL

☐ 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 ______________________________

Email completed form to htbilling@memun.org or fax (207) 624-0166
For questions, please call the Billing & Enrollment Dept. at 207-621-2645 or (within Maine) 800-452-8786 EXT. 2585

PLEASE RETAIN A COPY FOR YOUR RECORDS