MAINE MUNICIPAL
EMPLOYEES HEALTH TRUST
60 Community Drive | Augusta, ME 04330-9486
(207) 621-2645 or 1-800-852-8300 | www.mmeht.org

MMEHT OFFICE USE ONLY
Subgroup No.
Effective Date
Status
Entered by:

DENTAL PLAN APPLICATION ENROLLMENT/CHANGE FORM PLEASE PRINT

1. EMPLOYER SECTION

Employer

Date of Employment | Hours worked per week

Enrollment Reason:
- ☐ New Hire
- ☐ Newly Eligible on (date & reason) _____
- ☐ New Group (initial enrollment)
- ☐ Open Enrollment
- ☐ Portability/Qualifying Event

2. PLAN CHOICE

I elect to be insured at the ☐ **Employee Only** ☐ **Employee/Spouse** ☐ **Employee/Child** ☐ **Family** level of coverage and hereby authorize my employer to withhold from payroll the amount necessary to make coverage effective.

3. NAME, ADDRESS & TELEPHONE

Employee Legal Name | Date of Birth | Gender ☐ Male ☐ Female ☐ Non-Binary | Social Security Number

Mailing Address | Home Phone: | Cell Phone:

Town | State | Zip | Work Phone:

4. CHANGE STATUS

Type of change: ☐ Address change ☐ Name change – provide previous name: _____
☐ Add dependent(s) listed below in section 5 ☐ Drop dependent(s) listed below in section 5

Reason for change: **Date of change or event** _____

☐ Adoption	☐ Birth	☐ Court order
☐ Covered by other insurance	☐ Death	☐ Discharge from the Military
☐ Divorce	☐ Dissolution of Domestic Partnership	☐ Entrance to the Military
☐ Involuntary loss of coverage	☐ Marriage	☐ Other _____

You may apply to cover your legal spouse, domestic partner (DP) (IF your employer offers this benefit and the Trust receives a completed MMEHT domestic partner affidavit, verifying qualification) and children between birth and 26 years of age.

5. FAMILY INFORMATION (IF ELECTING FAMILY COVERAGE)

Name (Last, First, MI)	Date of Birth Mo/Day/Yr	Social Security Number	Gender: Male	Female	Non-Binary
☐Spouse or ☐Domestic Partner			☐	☐	☐
Child			☐	☐	☐
Child			☐	☐	☐
Child			☐	☐	☐

6. SIGNATURE

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: _____

7. ELECTION NOT TO ENROLL

☐ I elect **not** to enroll in dental coverage during my new hire enrollment period. I understand I may choose to elect coverage later during open enrollment or with a qualifying event.

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