

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

MEDICAL PLAN APPLICATION ENROLLMENT/CHANGE FORM PLEASE PRINT

	Employer			Enrollment Reason: New Hire					
1.	Date of Employment	Elected Official (Yes or No)		□ Newly Eligible on (date & reason) □ New Group (initial enrollment) □ Open Enrollment					
EMPLOYER									
SECTION	Annual wages or salary	Hours worked per week	☐ Porta	bility or Qu	ualifying E				
						Union Change (not previously eligible)			
2.PLAN CHOICE	☐ Acadia (POS C) ☐ Baxter (POS				,,				
OHOICE	☐ Moosehead (PPO 1500) ☐ Pemaquid (PPO 2500) If you are enrolling in a medical plan, please also complete the MMEHT life enrollment form for submission.								
	Employee Legal Name						1		
3.	Employee Legal Name					Social Security Number			
Employee Name	Mailing Address					Home Phone:			
	-					Cell Phone:			
ADDRESS & TELEPHONE	Town	State	Zip			Work Pho	one:		
4.	Type of change: Address Change Name Change – provide previous name:								
Change	=	ent(s) listed below in sect					d below in section 5		
STATUS	Reason for change:		[Date of ch	ange or e	event:			
	Adoption	☐ Birth (if grandchi	ld see belov		Court o				
	☐ Covered by other insurance☐ Divorce	☐ Death ☐ Dissolution of Do	omestic Part	nership [☐ Entrand	rge from the ce to the Mili	itary		
	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 form verifying qualification) and children between birth and 26 years of age.								
5.							of age.		
5.		form verifying qualification	n) and child te of Birth	ren betwee	en birth ar Gender	nd 26 years	Social Security		
5.	MMEHT Domestic Partner Affidavit	form verifying qualification	n) and child		en birth ar	nd 26 years	1		
5. MEMBER	MMEHT Domestic Partner Affidavit	form verifying qualification	n) and child te of Birth	ren betwee	en birth ar Gender	nd 26 years Non-	Social Security Number		
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