



**EMPLOYEE ENROLLMENT FORM**

<b>Employer</b>	<b>Date of Hire</b>	<b>Annual Salary</b>
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Employee Name _____ Soc. Sec. # _____
Employee Address: _____
Phone (H) _____ (W) _____ Gender ____ Marital Status ____ Date of Birth _____

**I would like to enroll in the following Life Insurance coverage(s):**

**Type of Coverage** – Check coverage and level option(s) desired only if offered by your employer

- Basic Life
- Supplemental Life  Please enroll me for:  1x  2x  3x salary.
- Dependent Life  Please enroll me in:  Option A  Option B

**Dependent Information:** Complete only if enrolling in Dependent Life

Name	Date of Birth	Relationship

**Beneficiary Designation:** Note: Please designate each name as Primary (P) or Contingent (C) in last column

Name	Relationship	Address	Percentage	P or C

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. If I do not elect the health coverage, I understand that I have the option to enroll in Basic Life for a monthly premium. I authorize the deduction from my earnings of any contribution I am required to make toward the cost of this insurance.

**Enrolling in Life Insurance:** Signature \_\_\_\_\_ Date: \_\_\_\_\_

I do not wish to enroll in **Basic Life** , **Supplemental Life** , or **Dependent Life** , at this time. I understand that if I do not enroll when I am first eligible, I will be subject to Evidence of Insurability at a later date. (Please check all appropriate boxes as indicated above.)

**Not Enrolling in Life:** Signature \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE READ IMPORTANT INFORMATION ON THE BACK OF THIS FORM**