Maine Municipal
Employees Health Trust
www.mmeht.org

TERMINATION NOTIFICATION FORM

Please list below all employees for whom you have **DELETED PAYMENT** on this month's billing, giving the reason for termination of coverage (see list), date of event and current address. **Return this form to the Health Trust with your monthly bill when you remit your Premium.**

Date=Last ACTIVE Day of Work or Date for a "C" Cancellation request				EMPLOYER USE ONLY	FOR MMEHT USE ONLY		
				Employee's Name & Mailing Address	Dependents' Names	Start Dates	Life Vol.
Code:	Date:			Employee	Employee End Date		EE
				ID#:	Dep 1		SP
Request to cancel "C" coverage(s) Check all boxes that apply.	Health ☐	Life ☐		Address	Dep 2		DEP
	IPP ☐	Dental ☐		City/State	Dep 3		
	Vision ☐	LTD ☐			Dep 4		
Code:	Date:			Employee	Employee End Date		EE
				ID#:	Dep 1		SP
Request to cancel "C" coverage(s) Check all boxes that apply.	Health ☐	Life ☐		Address	Dep 2		DEP
	IPP ☐	Dental ☐		City/State	Dep 3		
	Vision ☐	LTD ☐			Dep 4		
Code:	Date:			Employee	Employee End Date		EE
				ID#:	Dep 1		SP
Request to cancel "C" coverage(s) Check all boxes that apply.	Health ☐	Life ☐		Address	Dep 2		DEP
	IPP ☐	Dental ☐		City/State	Dep 3		
	Vision ☐	LTD ☐			Dep 4		

Reason for Coverage Termination:

Code	Reason	Code	Reason
T	Involuntary Termination	H	Reduction of Hours making them ineligible for coverage
V	Voluntary Resignation	M	Retirement – Contributed to MEPERS
L	Temporary Layoff	R	Retirement – Did not contribute to MEPERS
A	Leave of Absence	W	Work Related Injury or Occupational Disease
C	Cancellation Requested	X	Active Employee chooses Medicare & cancels HT
D	Death of the Employee - Note Date of Death	F	Military
E	Disability		

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Municipality/Employer Name

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Signature of Person Completing

05/07/14