State of Maine
Office of Employee Health & Benefits
61 State House Station
Augusta, ME 04333-0061
www.maine.gov/bhr/oeh

CERTIFICATION FOR FUTURE ENROLLMENT
For Dependents of Retiree Group Health Plan Members

Instructions: Complete this form if you are **not** insuring your spouse/domestic partner and/or dependents at the time of retirement.

I. Retiree Information:

Retiree Name	Social Security Number
Department	Retirement Date

II. List name(s) below: Only those names listed below are eligible for future enrollment.

Name	Social Security Number	Date of Birth
Spouse/Domestic Partner		
Dependent		
Dependent		

*Note: To be considered for **one-time** re-enrollment, spouse/domestic partner and/or dependents must have had 18 months of health insurance coverage immediately prior to enrollment.*

I understand that I have the option to add my spouse/domestic partner and /or eligible dependent(s) at a future date as provided in 5 MRSA §285, sub-§3-B. I must contact the Office of Employee Health & Benefits at (207) 624-7380 or 1-800-422-4503 to obtain an insurance application.

III. Retiree Signature _____ **Date:** _____

If applicable, this completed form must accompany the Application for Retired Health Insurance Transfer within 60 days of retirement. Mail completed forms to: **Employee Health & Benefits, 61 State House Station, Augusta, ME 04333-0061**

EH&B Use Only:

EH&B Approval: _____	Type of Plan: _____
Date: _____	Group Number: _____
	Effective Date: _____

Original – EH&B **Copy - Retiree**

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