

STATE OF MAINE

Anthem Vision Application/Change Form

All sections need to be completed before this application can be processed.

1. Applicant Information:

Last Name	First Name	MI	Date of Birth	Social Security Number
Home Address		City	State	Zip
				Home Phone:
				Work Phone:
Please check one: I am currently an <input type="checkbox"/> Active Employee OR <input type="checkbox"/> Retiree in department: _____				Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female

2. Reason for Application:

- New Hire (Date of Hire is _____) Change Address/Name/Phone Number
- Cancel Coverage (Life event required; see below)
- Change of Coverage (e.g. add or delete spouse/dependents/domestic partner) (Life event required; see below)

3. Qualifying Life Event:

- Marriage – date: _____ Death – date: _____
- Divorce – date: _____ Involuntary Loss of Coverage – date: _____
- Birth or Adoption – date: _____ Change in Employment – date: _____
- Leave of absence (begin/end) – date: _____
- Other (please specify & include date): _____

4. Applicant and Family Information:

Add/Remove	Last Name	First Name	MI	Birth Date	SSN	Gender
<input type="checkbox"/> Add <input type="checkbox"/> Remove	Self					<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Spouse or <input type="checkbox"/> Domestic Partner					<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Add <input type="checkbox"/> Remove	Dependent					<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Add <input type="checkbox"/> Remove	Dependent					<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Add <input type="checkbox"/> Remove	Dependent					<input type="checkbox"/> Male <input type="checkbox"/> Female

4. Applicant Signature:

I am requesting coverage for myself and all dependents listed and authorize my employer to deduct any required contributions for this insurance from my earnings. 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 an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits. I understand all benefits are subject to conditions stated in the group agreement and Certificate of Coverage.

Applicant Signature Date

5. Election NOT to Enroll:

I do NOT wish to enroll in this plan and understand that the opportunity to enroll at any future date will be subject to the regulations of Anthem Vision.

Applicant Signature Date

Send completed form to: State of Maine, Employee Health & Benefits, 114 State House Station, Augusta, ME 04333-0114 OR via fax to 287-6796 (note: If sending via fax, do not send original copy)

6. Employer Information: To be completed by Employer

Employer State of Maine	Group Number MS3030	Division V	Effective Date
----------------------------	------------------------	---------------	----------------