FIREFIGHTERS AND LAW ENFORCEMENT OFFICERS INSURANCE SUBSIDY PROGRAM

REV. 4/1/25

Application for Retirement Subsidy

Enrollment in this program is subject to the enrollment and eligibility requirements of the applicable group health plan. Eligibility for this program will be determined based on the rules and regulations that govern the program. If you have any questions, please contact the Division of Employee Health, Wellness, & Workers' Compensation at 207-624-7749. Please return form to: Department of Employee Health, Wellness, & Workers' Compensation, 61 State House Station, Augusta, Maine 04333-0114. Email: Info.FFLEO@maine.gov

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Employer Section: Fire _____ Police _____ Title of Position Held _____ph#_____

NAME _____ (Please Print Clearly) _____ SSN _____ - _____ - _____

ADDRESS _____ DATE OF BIRTH _____ /_____ /_____

CITY _____ STATE _____ ZIP _____PHONE _____

EMPLOYER NAME: _____ TOTAL YEARS OF SERVICE: _____

HIRE DATE: _____ RETIREMENT DATE: _____ Date Health Ins. Ends: _____

Is the plan participant currently enrolled with the employer's health plan? Yes _____ No _____

Name of Employer's Health Insurance Company: _____

Name of employer sponsored retirement plan which the employee participates in? MEPERS _____ ICMA_____ OTHER_____
Name of Plan

Employee Section: For more information on any of the provisions below, please contact our Office at 207-624-7749

Please check where your will be obtaining your health insurance as a retiree:

- ☐ I elect to enroll as a retiree in the Insurance Subsidy Plan with my municipalities' health insurance plan.
- ☐ I currently have health insurance coverage through my spouse and elect to have the insurance Subsidy contributions made towards this plan. (Documentation Required). Contact EHW&WC for forms.
- ☐ I elect to enroll in the State of Maine retiree health insurance plan if applicable to my municipality. (Enrollment form required).
- ☐ I elect NOT to enroll in the Insurance Subsidy Plan at this time because I have coverage thru my new employer at no cost to me.
- ☐ I elect to enroll in my new employer plan and request reimbursement for my portion of the premium (Documentation Required) Contact EHW&WC for forms.
- ☐ Retiree- return to work – Special re-enrollment provisions apply
- ☐ I elect not to enroll and understand I may not be able to re-enroll later. Restriction Apply.
- ☐ I am not eligible for the subsidy until age 50. I must stay continuously enrolled in health insurance and will contact the office of EHW&WC at age 50 for enrollment information.

By signing below, I certify that all information supplied on this form is true and accurate to the best of my knowledge. I also give my authorization to the Division of Employee Health, Wellness, & Workers' Compensation to obtain all information necessary to comply with the rules, regulations and statutes that govern the Retired Fire Fighters and Law Enforcement Officers Insurance Subsidy Program.

Employee Signature: _____ Date: _____

EHW&WC Use Only: Eligible for subsidy YES____NO ____ Not eligible for subsidy - Reason _____Date_____