# State of Maine: Group Benefit Plans Enrollment/Change Form

Employee Health, Wellness, & Workers' Compensation, 61 State House Station, Augusta ME 04333-0061 **e-mail:** info.benefits@maine.gov **phone:** (207)624-7380 or 1-800-422-4503 www.maine.gov/bhr/oeh

## 1. Subscriber Information

| Last Name | First Name | M. I. | Social Security Number | Date of Birth | Marital Status: ☐ Married ☐ Single ☐ Divorced | Gender ☐ Male ☐ Female ☐ Undefined |
|---|---|---|---|---|---|---|
| | | | | | | |

| Mailing Address | City | State | Zip | Telephone : ( ) | E-mail Address: |
|---|---|---|---|---|---|
| | | | | | |

**2. Employer/Department:**

*Working for or retired from:*

Employer:

☐ State of Maine

☐ Other

_____

(E.g. MCCS, MainePERS, etc.)

**and**

Department Name:

_____

(E.g. DHHS, DOT, DOC, etc.)

**3. Current Employment Status :**

*Check one below*

☐ Active Employee

☐ Intermittent Employee

☐ Retiree

☐ Surviving Spouse/ Dependent

**4. Reason for Application: (Required)**

**a. Change in Employment:**

☐ New Hire ☐ Rehire ☐ Return from Leave of Absence ☐ Recall from Layoff

**(State of Maine Employees Only) TAMS ID:** _____ **Date of hire/rehire/return/recall (required):** _____ / _____ / _____

**b. Qualifying Life Event:** ***Documentation required*** Visit www.maine.gov/bhr/oeh for qualifying life event list

☐ Annual Enrollment *(only held in May each year; effective date of change is July 1st)*

☐ Life Event Reason:_____

**Date of Life Event (required):** _____ / _____ / _____

**c. Name and/or Address Change:**

☐ Address Change

☐ Name Change _____

*Former Name*

**Date of Name Change/ Address Change (required):** _____ / _____ / _____

**5a. Family Information** If you need extra space, please print another form from our website www.maine.gov/bhr/oeh or request from your human resources department

**List only family members enrolling, or for whom change in coverage is needed**

**5b. Plan Selection**

| Last Name | First Name | Social Security Number | Date of Birth | Gender | Doctor's Full Name and Anthem PCP ID Number www.Anthem.com | Health Insurance | Dental Insurance | Vision Insurance |
|---|---|---|---|---|---|---|---|---|
| Self | | | | ☐ Male ☐ Female ☐ Undefined | Current Patient? ☐ Yes or ☐ No | ☐ Enroll ☐ Delete ☐ Decline | ☐ Enroll ☐ Delete ☐ Decline | ☐ Enroll ☐ Delete ☐ Decline |
| ☐ Spouse *or* ☐ Domestic Partner **State of Maine employee?** ☐ Yes or ☐ No **(Marriage license or partner affidavit required)** | | | | ☐ Male ☐ Female ☐ Undefined | Current Patient? ☐ Yes or ☐ No | ☐ Enroll ☐ Delete ☐ Decline | ☐ Enroll ☐ Delete ☐ Decline | ☐ Enroll ☐ Delete ☐ Decline |
| Child **(Birth certificate or court documentation required)** | | | | ☐ Male ☐ Female ☐ Undefined | Current Patient? ☐ Yes or ☐ No | ☐ Enroll ☐ Delete ☐ Decline | ☐ Enroll ☐ Delete ☐ Decline | ☐ Enroll ☐ Delete ☐ Decline |
| Child **(Birth certificate or court documentation required)** | | | | ☐ Male ☐ Female ☐ Undefined | Current Patient? ☐ Yes or ☐ No | ☐ Enroll ☐ Delete ☐ Decline | ☐ Enroll ☐ Delete ☐ Decline | ☐ Enroll ☐ Delete ☐ Decline |

**I certify all information supplied on this form is true and complete to the best of my knowledge and/or belief. I understand the effective date and termination date of my membership will be determined by the Office of Employee Health, Wellness, & Workers' Compensation in accordance with rules, regulations & statutes. I further authorize Office of Employee Health, Wellness, & Workers' Compensation to deduct any premiums owed by me as of the date my application is approved. I understand my employer has given me and my dependents (if applicable) an opportunity to apply for group health coverage that provides Minimum Value and Minimum Essential Coverage that is affordable.**

**Misrepresentation: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. My signature on this application constitutes my approval and authorization for Anthem Blue Cross and Blue Shield to enforce the State of Maine Plan's subrogation rights for my claims on a just and equitable basis. I consent to receive e-mails from the Office of Employee Health, Wellness, & Workers' Compensation that are serviced by Constant Contact that contain important benefit information. You may revoke your consent to receive e-mails via the Constant Contact service at any time by using the SafeUnsubscribe® link found at the bottom of every e-mail.**

**Disclosure: By signing and dating this form, you here by give the Office of Employee Health, Wellness, & Workers' Compensation the permission to communicate to you through email to the email address you have provided above.**

**Signature** _____ **Date** _____

## 6. Group Information: To be completed by the State of Maine Office of Employee Health, Wellness, & Workers', Compensation only.

| Plan Sponsor: State of Maine<br>SOM Department #:<br>Benefits Specialist: | Payroll Code | Health Effective Date _____ / _____ / _____<br>Anthem Firm Division# 00M_____ | Dental Effective Date _____ / _____ / _____<br>___ 601 State of Maine<br>___ 602 Ancillary Groups: Sublocation _____<br>DD01 DD02 DD03 | Vision Effective Date _____ / _____ / _____<br>Anthem Firm Division# 0VM_____ |
|---|---|---|---|---|