State of Maine
Office of Employee Health, Wellness, & Workers' Compensation
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-§3-8. I must contact the Office of Employee Heath, Wellness, & Workers' Compensation at (207) 624-7380 or 1- 800-422-4503 to obtain an insurance application.

III. **Retiree Signature**____ **Date:**______________

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

EHW&WC Use Only:

EHW&WC Approval: ________________ Type of Plan: ______________________________

Date: ____________________ Group Number: ____________________________

Effective Date: ____________________________