



Janet T. Mills, Governor  
 Kirsten LC Figueroa, Commissioner

## EMPLOYEE ELECTION TO CANCEL HEALTH INSURANCE

Employee Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Department Name: \_\_\_\_\_

Health Plan ID#: \_\_\_\_\_ Group # \_\_\_\_\_

I am requesting cancellation of my health insurance plan under the Maine State Employees Health Insurance Program for the following reason:

\_\_\_\_\_ Change in hours – Full time to Part time within the past 60 days.

\_\_\_\_\_ Commencement of other health insurance coverage within the past 60 days.

\_\_\_\_\_ My contribution level has increased within the past 60 days and I do not wish to pay the additional premium.

\_\_\_\_\_ Annual Enrollment

\_\_\_\_\_ Other (Provide specific qualifying life event to determine eligibility. The list of qualifying life events can be viewed on our website at [www.maine.gov/bhr/oeh](http://www.maine.gov/bhr/oeh)) \_\_\_\_\_

By signing this document:

- I understand if I plan to retire from the State of Maine or any of its Ancillary Group Employers covered by the Maine State Employees Health Insurance Program and wish to have health insurance benefits as a retiree, I must be enrolled for one full year immediately prior to retirement; AND
- Any State or employer contribution towards that benefit depends upon my first employment date and the number of years I was enrolled as an employee in the health insurance plan.

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date

Mail completed form to Employee Health & Benefits, 61 State House Station, Augusta, Maine 04333-0061 or e-mail to [Info.Benefits@Maine.gov](mailto:Info.Benefits@Maine.gov).

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