HEALTH INSURANCE SUBSIDY PROGRAM FOR LAW ENFORCEMENT OFFICERS & FIREFIGHTEI

Employee Election Application

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

ADDRESS _____ **DATE OF BIRTH** _____ / _____ / _____

CITY _____ **STATE** _____ **ZIP CODE** _____

EMPLOYER NAME _____ **DATE OF HIRE** _____/_____/_____
REQUIRED REQUIRED

Firefighter ☐ **Law Enforcement** ☐ **EE Email** _____

Position _____ **Work Phone** _____ **Cell** _____

Are you enrolled in an Employer-Sponsored retirement plan other than Social Security? YES: ☐ **NO:** ☐

Name of Plan: _____

(Enrollment is required in either MEPERS, ICMA, 401K, 401A, 403B, or a 457 Defined Contribution plan to be eligible to enroll in the FF-LEO Retiree Health Insurance Subsidy Program) Years of Service as a Fire Fighter or Law Enforcement Officer must be while working in the State of Maine.

You have 60 days from your date of hire to participate or not participate in the retiree subsidy health insurance program. However, you can also enroll within 5 years of your date of hire. Applying for participation in the program after your initial date of hire, employees must pay back 2% of their gross earnings from the date of hire to the date of enrollment into the program up to 5 years from their date of hire. The contribution rate going forward will be 1.5% of the employees' gross earnings. The municipality must provide a summary report showing wages/contributions by month and year for retro monies due. For more information, please contact the office of Employee Health, Wellness & Workers' Compensation at 207-624-7749.

☐ **I ELECT TO ENROLL** as a New Hire enrolling within 60 days from the date of hire. I authorize my employer to deduct the proper contributions from my wages and remit these funds to the State of Maine. **I understand the funds contributed are to be used only for the purposes of the health insurance subsidy program and that I DO NOT have any right to these funds except for the payment of retiree insurance premium subsidies.**

☐ **I ELECT TO ENROLL as a New Hire enrolling AFTER 60 days from the date of hire, but within 5 years from the date of hire.** **Employees must pay back 2% of their gross earnings from the date of hire to the date of enrollment into the program. The contribution rate going forward will be 1.5% of the employees' gross earnings. The municipality must provide a summary report showing wages/contributions by month and year for monies due.** I agree to pay retro contributions owed to enroll in the program. I authorize my employer to deduct the proper contributions from my wages and remit these funds to the State of Maine. **I understand the funds are to be used for the purposes of the subsidy program only, and that I DO NOT have any right to these funds except for the payment of retiree insurance premium subsidies.**

☐ **I ELECT NOT TO ENROLL** and understand I have 5 years from my date of hire to re-enroll with retro subsidy amounts due.

Employee Signature _____ **Date** _____ / _____ / _____

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☐ **RETIREE RETURN TO WORK - I ELECT TO ENROLL** in the Health Insurance Subsidy Program and by signing below, I authorize my employer to deduct 1.5% of my gross wages and remit these funds to the State of Maine. If you were not previously enrolled in this program, you are not eligible to enroll as a retiree returning to work. **I understand the funds are to be used for the purposes of the subsidy program only, and that I DO NOT have any right to these funds except for the payment of retiree insurance premium subsidies.**

☐ **I ELECT NOT TO ENROLL** in the Health Insurance Subsidy Program. Declining as a Retiree Return to Work will forfeit my insurance subsidy at the time of retirement if I was enrolled in the program previously. I understand that future enrollment will not be allowed.

Employee Signature _____ **Date** ____ / _____ / ____

FOR OFFICE USE ONLY - Employer only: Return form to FF-LEO-State of Maine EHW&WC, 61 State House Station, Augusta, Maine 04333. Info.FFLEO@Maine.gov

Eligible ☐ Not Eligible ☐ Enrolled in Health Insurance? Yes ☐ No ☐ Ins. Carrier Name: _____

Plan:

Single ☐ Adult w/child ☐
2 Person/Spouse ☐ Municipality HR personnel ☐
Family ☐

Phone:_____
Email: _____