STATE OF MAINE
DEPARTMENT OF ADMINISTRATIVE & FINANCIAL SERVICES
BURTON M. CROSS BUILDING, 4TH FLOOR
61 STATE HOUSE STATION
AUGUSTA, MAINE 04333

FF-LEO REIMBURSEMNT SUBSDIY FORM
FOR RETIREE HEALTH INSURANCE

Please check only one box and complete the required information

☐ **Individual Policy Reimbursement**

Name of Retiree/Employee: ____Date of Birth: ____________________

Social security number: __________________________ Town Retired from: ____________________________________

Address of Retiree :____

City: ____ STATE: __________ ZIP: _________________________

Total monthly premium for single coverage: ____________________________ Retiree ph: _________________________

Health Insurance Carrier: _________________________________ Renewal dates of Health Plan: ____________________

☐ **Employer Reimbursement**

Name of Retiree/Employee: ____ Date of Birth__________________

Social security number: __________________________ Town Retired from____________________________________

Total monthly premium for single coverage: ____________________________

Name of Employer: ____ ph:_______________________

Address of Employer: ____

____

Email address of Employer ____

Health Insurance Carrier: _________________________________ Renewal dates of Health Plan:____________________

Please include letter from Employer confirming cost of health insurance

☐ **Spouse Employer Reimbursement**

Name of Retiree: ____ Date of Birth of Retire: ________________

Name of Spouse: ____ Retiree PH: _______________________

Total monthly cost for spouse to insure dependent: ____________________________________

Health Insurance Carrier: _________________________________ Renewal dates of Health Plan: ____________________

Please include letter from Employer confirming cost of health insurance

Name of Authorized Employer Representative: ____

E-mail of Authorized Employer Representative: ____

Phone number of Employer contact: _____________________ Email : ____