HEALTH INSURANCE SUBSIDY PROGRAM FOR LAW ENFORCEMENT OFFICERS & FIREFIGHTERS

Employee Election Application

NAME _____ **Male___Female___SSN** _____ - _____ - _____
(Please Print Clearly)

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

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

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

Firefighter ___ Law Enforcement ___ Total Years of Service ____ 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 MainePERS, ICMA, 401K, 401A, 403B and 457 defined contributions plans.

New Hires: You have 60 days from your date of hire to participate or not participate in this program. However, you can also enroll within 5 years of your date of hire if you are hired after October 1, 2019. Applying for participation in the program after your initial date of hire, employees must pay back 2% of their gross earnings from date of hire to 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 ELECT TO ENROLL** as a New Hire enrolling within 60 days from date of hire of 10/1/2019 or later 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 TO ENROLL** as a New Hire enrolling after 60 day from date of hire of 10/1/2019 or later, but within 5 years from date of hire. 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** in the Health Insurance Subsidy Program. I understand that future enrollment may not be allowed.

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

****

Open Enrollment Provision: If hired prior to 10/1/2019 and not currently enrolled, there will be an open enrollment period from 10/1/2019 thru 12/31/2021. Employees must pay back 1.5% of their gross earnings for the first 5 years from their date of hire and 3% for any additional years until 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 ELECT TO ENROLL** during Open Enrollment as an existing employee hired prior to October 1, 2019 and enrolling between 10/1/2019 thru 12/31/2021. I agree to pay the 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** in the Health Insurance Subsidy Program. I understand that future enrollment may not be allowed.

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

****

_____ **RETIREE RETURN TO WORK - I ELECT TO ENROLL** in the Health Insurance Subsidy Program and by signing below, 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** in the Health Insurance Subsidy Program. Declining as a Retiree Return to Work will forfeit my insurance subsidy at time of retirement. I understand that future enrollment may not be allowed

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

Employer only: Return form to FF-LEO-State of Maine EHB, 61 State House Station, Augusta, Maine 04333. Email to: Joan.M.Hanscom@maine.gov

Eligible ____ Not Eligible ____ Enrolled in Health Insurance? Yes ____ No ____Ins. Carrier Name: _____Plan: Single ____

2 Person/Spouse _____ Family _____ Adult w/child _____ Municipality HR personnel _____

Phone:_____ Email: _____