** 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 \_\_\_ 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)**

**New Hires: 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 date of hire to 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 at 207-624-7749.**

**\_\_\_\_\_\_** I **ELECT TO ENROLL** **as a New Hire enrolling within 60 days from 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 date of hire, but within 5 years from 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 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 will not be allowed.

**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 return 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 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 EH&W, 61 State House Station, Augusta, Maine 04333. Email to:[**Joan.M.Hanscom@maine.gov**](mailto: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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FF-LEO Enrollment Form Rev 1.2023