STATE OF MAINE
Office of Employee Health, Wellness, & Workers' Compensation
One Time Election of Health Insurance Form

I. Employee Information:

Name	Department	Hire Date	Termination Date
		☐First hired by the State of Maine prior to July 1, 1991	
Address	City	State	Zip Code
	Home Phone ( )	Date of Birth	Social Security Number

II. Current Health Insurance Coverage: (select one)

___ Single ___ 2-Person ___ Family ___ Adult w/Children ___ Dual Employee Family Contract

Name(s)	Social Security Number	Date of Birth
Spouse/Domestic Partner	- -	/ /
Dependent	- -	/ /
Dependent	- -	/ /
Dependent	- -	/ /

I understand: (1) this is my one-time election as provided by the governing State of Maine Statute Title 5 §285 to preserve retiree medical insurance enrollment rights and (2) if I fail to maintain coverage under the State of Maine group, I will only be able to reenter the group at the time I elect to retire. Link to Statute is available at www.maine.gov/bhr/oeh.

III. Please check one:

_____ I elect to continue health coverage and remain in the State of Maine group; I understand I will be billed directly. Current premium $_____/month

OR

_____ I elect not to continue my health insurance coverage and will only be permitted to reenter the State of Maine group at the time I elect to retire per Title 5 §285.

I understand at the time I retire, I must contact the Office of Employee Health, Wellness, & Workers' Compensation at least 60 days in advance or retirement to complete an application to transfer my health insurance into retirement status.

IV. Signature _____ Date: _____

Return completed form to: Employee Health, Wellness, & Workers' Compensation, 61 State House Station, Augusta, Maine 04333-0061. For questions call (207)624-7380 or 1-800-422-4503 (TTY dial Maine Relay 711).

Please note: Employee Health, Wellness, & Workers' Compensation may verify retirement eligibility with the Maine Public Employees Retirement System as necessary.

EH&W Use Only:

First Hire Date: _____	Direct Bill Group Effective Date:
Years of participation in State group health plan: _____	_____ Month Day Year
Percent of State paid retirement benefit: _____%	Group Number: _____

Original – EHW&WC *Copy - Retiree*

Revised 04/2025