



**FIREFIGHTERS AND LAW ENFORCEMENT OFFICERS  
INSURANCE SUBSIDY PROGRAM  
Application for Retirement Subsidy**

REV. 10.21

Enrollment in this program is subject to the enrollment and eligibility requirements of the applicable group health plan. Eligibility for this program will be determined based on the rules and regulations that govern the program. If you have any questions, please contact the Division of Employee Health & Wellness at 207-624-7682. Please return form to: Department of Employee Health & Wellness, 61 State House Station, Augusta, Maine 04333-0114, or email to: Joan.M.Hanscom@maine.gov

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**Employer Section:** Fire Fighter \_\_\_\_\_ Law Enforcement \_\_\_\_\_ Title of Position Held \_\_\_\_\_

NAME \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
(Please Print Clearly)

ADDRESS \_\_\_\_\_ DATE OF BIRTH \_\_\_\_ / \_\_\_\_ / \_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ PHONE \_\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_ TOTAL YEARS OF SERVICE: \_\_\_\_\_

HIRE DATE: \_\_\_\_\_ RETIREMENT DATE: \_\_\_\_\_ Date Health Ins. Ends: \_\_\_\_\_

Is the plan participant currently enrolled with the employer's health plan? Yes \_\_\_\_\_ No \_\_\_\_\_

Name of Employer's Health Insurance Company: \_\_\_\_\_

Name of employer sponsored retirement plan which the employee participates in? MEPERS \_\_\_\_\_ ICMA \_\_\_\_\_  
OTHER \_\_\_\_\_  
Name of Plan

**Employee Section:** For more information on any of the provisions below, please contact the Office of EH & B @ 624-7682

Please check where your will be obtaining your health insurance as a retiree:

- I elect to enroll as a retiree in the Insurance Subsidy Plan with my municipalities' health insurance plan.
- I currently have health insurance coverage through my spouse and elect to have the insurance Subsidy contributions made towards this plan. Documentation required.
- I elect to enroll in the State of Maine retiree health insurance plan if applicable to my municipality. (Enrollment form required)
- I elect NOT to enroll in the Insurance Subsidy Plan because I have coverage thru my new employer.
- I elect to enroll in my new employer plan and request reimbursement for my portion of the premium (Documentation Required)
- Retiree return to work – Special re-enrollment provisions apply
- I elect not to enroll and understand I may not be able to re-enroll later.
- I am not eligible for the subsidy until age 50. I must stay continuously enrolled in health insurance and will contact the office of EH & W at age 50 for enrollment information.

By signing below, I certify that all information supplied on this form is true and accurate to the best of my knowledge. I also give my authorization to the Division of Employee Health & Wellness to obtain all information necessary to comply with the rules, regulations and statutes that govern the Retired Fire Fighters and Law Enforcement Officers Insurance Subsidy Program.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

EH&B Use Only: Eligible for subsidy YES \_\_\_\_\_ NO \_\_\_\_\_ Not eligible for subsidy - Reason \_\_\_\_\_ Date \_\_\_\_\_