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

FF-LEO DIRECT REIMBURSEMENT SUBSIDY FORM FOR RETIREE HEALTH INSURANCE

Please check only one box and complete the required information

☐ **Individual Policy Reimbursement – Option #1**

Name of Retiree/Employee: _____Date of Birth: _____

Social security number: _____ Town Retired from: _____

Address of Retiree: _____PH: _____

City: _____ STATE: _____ ZIP: _____

Monthly cost employee pays for single coverage: _____Renewal dates of Health Plan:_____

EMAIL Address: _____

Retiree Signature: _____Date: _____

Please include a letter confirming coverage cost and the effective date

☐ **Employer Reimbursement- Option #2**

Name of Retiree/Employee: _____ Date of Birth_____

Social security number: _____ Town Retired from_____

Monthly premium the retiree pays for single coverage: _____RETIREE EMAIL_____

Name of Employer: _____ PH: _____

Address of Employer: _____

Email address of Employer _____

Health Insurance Carrier: _____ Renewal dates of Health Plan: _____

Retiree Signature: _____Date: _____

Please include a letter confirming coverage, cost, and effective date

☐ **Spouse Employer Reimbursement- Option #3**

Name of Retiree: _____ Date of Birth of Retire: _____

Name of EE/Spouse: _____ Retiree PH: _____

Total monthly cost to insure just the dependent(retiree)_____

Health Insurance Carrier: _____ Renewal dates of Health Plan: _____

Please include a letter from the Employer confirming coverage, cost, and effective date

Name of Authorized Employer Representative: _____Date_____

E-mail of Employer Representative: _____ Ph: _____

Retiree Signature: _____ Date: _____

REV 7/2025