STATE OF MAINE
Office of Employee Health & Wellness
Request to Decline or Withdraw from Coverage

I. **Retiree Information:**

Retiree Name	Social Security Number	Retirement Date	
Address	City	State	Zip Code

II. **Please circle ONE:**

I wish to **DECLINE** or **WITHDRAW** coverage under the State of Maine Health Insurance Program.

I certify that I am a retiree who is eligible for State health insurance pursuant to 5 MRSA §285, sub-§1-G. Please visit www.maine.gov/bhr/oeh to access governing statute. I understand that I have the option to reenroll at a later date as longas I have met the provisions stated in 5 MRSA §285, sub-§3-C.

III. **Retiree Signature** _____ Date: _____

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

EH&W Use Ont :

EH&W Approval:____ _ Date: _____	Type of Plan:_____ Group Number:_____ Effective Date:_____

Original - EH&W Copy - Retiree