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

Please Note: Entire form must be completed and returned regardless of choice of enrolling or not

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, & Workers' Compensation at 1-800-422-4503. Please return form to: Department of Employee Health, Wellness, & Workers' Compensation, 61 State House Station, Augusta, Maine 04333-0114 or email to: Susan.Ryerson@maine.gov

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Employer Section:

Firefighter _____ 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: _____

DATE OF HIRE: _____ DATE OF RETIREMENT: _____

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

Date Active Health Insurance Ends: _____

Name of Employer's Health Insurance Company: _____

Which employer sponsored retirement plan does the member participate in? MainePERS _____ICMA_____
OTHER_____
Name of Plan

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Employee Section:

Please check one:

- ☐ **I elect to enroll as a retiree in the Insurance Subsidy Plan and will be enrolling in my municipalities' retiree 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. Contact Office of EHW&WC for more information at 207-624-7749.**
- ☐ **I elect to enroll in the State of Maine retiree health insurance plan if applicable to my municipality**
- ☐ **I elect NOT to enroll in the Insurance Subsidy Plan because I have coverage through my new employer. I understand that future enrollment as a retiree may not be allowed. Contact office of EHW&WC for more information.**
- ☐ **Retiree return to work – Special re-enrollment provisions apply**

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, & Workers' Compensation 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: _____

EHW&WC Use Only: Eligible for subsidy YES____NO ____ Not eligible for subsidy - Reason
_____Date_____ Retirement Subsidy App. REV. 4/2025