

## STATE OF MAINE DEPARTMENT OF ADMINISTRATIVE & FINANCIAL SERVICES

Bureau of Human Resources
Division of Employee Health, Wellness & Workers' Compensation
61 State House Station
Augusta, ME 04333-0114



## HEALTH INSURANCE SUBSIDY PROGRAM FOR LAW ENFORCEMENT OFFICERS AND FIREFIGHTERS Status Change Form

Employee Information:	☐ Phone Change ☐ A	Address Change	
□ Name Change	(0111)	New Name:	
Name:		EE Email:	
Mailing Address:			
SSN:		/ Date of Hire://	
Reason for Change:			
☐ Termination date:/_	/ □ Date a	active health insurance ends//	
☐ Retirement date:/	<b>/</b> □ Retire	ee return to work: /	
☐ Withdrawal date:/_	<b>/</b> □ Trans	sfer date: /	
□ Other: Reason	Dat	tes/	
		Other:    h & Benefits when the employee starts and returns	
☐ Going from Full time to Part	time no longer eligible to	o continue with Program/	
		refighter/Law Enforcement Position//	
		ipality, the employee is eligible to continue the FF/LE unicipality if the new municipality participates in the S	
Please list name of new munici	pality if known:		
Municipality Information:			
Contact Person:		Phone:	
E-mail:			
Employer Signature:			