





1. Subscriber Information	n												
Last Name		First Name	M. I.	Social Secu	rity Number			Date of Birth	Marital Status:	_		Gender	
									Married	Single	_	e Female	
Mailing Address		City	State	Zip			Telephone :		Divorced E-mail Add	recc.	Und	lefined	
Mailing Address		City	State	Σιρ			reiepriorie .		L-mail Addi	1633.			
							( )						
2. Employer/Department:	3. Current E	Employment Status :	4. Reason fo	or Application	n: (Require			l .					
Working for or retired from:	ng for or retired from:  Check one below			a. Change in Employment:									
Employer:			☐ New Hir	☐ New Hire ☐ Rehire ☐ Return from Leave of Absence ☐ Recall from Layoff									
State of Maine	Active Employee			Date of hire/rehire/return/recall (required)://									
☐ Other ☐ Intermittent Employee			b. Qualifying Life Event: Documentation required Visit www.maine.gov/bhr/oeh for qualifying life event list										
		ent Employee	Annual	Annual Enrollment (only held in May each year; effective date of change is July 1st)									
(E.g. MCCS, MainePERS, etc.)			Life Eve	ent Reason:									
and	□ Datiros			Date of Life Event (required): / /									
<u>Department Name</u> :	ent Name:			a Nama and /ay Address Change:									
☐ Surviving Spouse/ Depen		Spouse/ Dependent	ependent c. Name and/or Address Change:										
(E.g. DHHS, DOT, DOC, etc.)		☐ Address Change ☐ Name Change											
( ) -, -,,,	Former Name  Former Name												
	Date of Name Change/ Address Change (requ										ired): / /		
5a. Family Inform		extra space, please prin			w.maine.gov	<u>//bhr/oeh</u> or re	equest from yo	our human resources de	partment	5	b. Plan Select	tion	
Last Name		First Name		Social Security Number Date		Gender	Doctor's Full Name and Anthem P		PCP ID Number	Health	Dental Vision		
		i ii st italiie	Social Security 140	uniber Dat	e or birtir	Gender		www.Anthem.co	<u>m</u>	Insurance	Insurance	Insurance	
Self						Male				Enroll	Enroll	Enroll	
						Female Undefined	Current Paties	nt? ☐ Yes or ☐ No		Delete Decline	Delete Decline	Delete Decline	
Spouse <i>or</i> Domestic Partner							Current raties	iit:   Tes oi   No			Decline	Decline	
State of Maine employee? Yes or No						Male				Enroll	Enroll	Enroll	
						Female Undefined		Dv Dv.		Delete Decline	Delete Decline	Delete Decline	
(Marriage license or partner affidavit required)						Undefined	Current Patier	nt? Yes or No			Decline		
Child						Male				Enroll	Enroll	Enroll	
(Birth certificate or court documentation required)						Female		Dv Dv.		Delete	Delete	Delete	
Child						Undefined  Male	Current Patier	nt? Yes or No		Decline Enroll	Decline Enroll	Decline Enroll	
						Female				Delete	Delete	Delete	
(Birth certificate or court documentation required)						Undefined	Current Patie	nt? Yes or No		Decline	Decline	Decline	
I certify all information supp Wellness in accordance with dependents (if applicable) a misleading information to an Plan's subrogation rights for revoke your consent to recei Disclosure: By signing and di	rules, regulations & nopportunity to appl insurance company my claims on a just ave e-mails via the Co	statutes. I further autho ly for group health covera for the purpose of defrat and equitable basis. I co instant Contact service at	rize Employee Health & ige that provides Minin iding the company. My nsent to receive e-mail any time by using the	& Wellness to do mum Value and y signature on t ls from the Offic SafeUnsubscril	educt any pr Minimum Es his applicati ce of Employ be® link fou	emiums owed sential Coveragon constitutes ee Health & W nd at the botto	by me as of the ge that is afford my approval a ellness that are om of every e-n	e date my application is a dable. Misrepresentation nd authorization for Anth e serviced by Constant Conation.	approved. I understar : It is a crime to know nem Blue Cross and B ontact that contain in	nd my employer wingly provide fa lue Shield to enf nportant benefit	has given me a alse, incomplete force the State o	nd my or of Maine	
	•		-	·					-				
Signature			Da	ate			_						
Dian Change Chair and Market	Desire II Co. I.	6. Group in	formation: To be co	mpleted by S	tate of Ma	ine Office of	Employee He	ealth & Wellness only					
<u>Plan Sponsor</u> : State of Maine	Payroll Code	Health Effective Date	/		Dental	Effective Date	/	/	Vision Effective	ve Date /	/		
SOM Department #:							601 State of Maine 602 Ancillary Groups: Sublocation						
Benefits Specialist:		Anthem Firm Division# 00M				DD01 DD02 DD03				Division# 0VM			