





1. Subscriber Information	n											
Last Name		First Name	M. I.	Social Security Number	er		Date of Birth	Marital Status:			Gender	
								Married	Single	=	le Female	
Mailing Address		City	State	Zip	1	Telephone :		Divorced E-mail Addr	ecc.	Und	lefined	
Mailing Address		City	State	Zip		reiepriorie .		L-IIIaii Addi	C33.			
						()						
2. Employer/Department:	3. Current E	mployment Status :	4. Reason for	4. Reason for Application: (Required)								
Working for or retired from:	rking for or retired from: Check one below		a. <u>Change in</u>	a. Change in Employment:								
Employer:		HECK OHE DEIOW	□ 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			b. Qualifying	b. Qualifying Life Event: Documentation required Visit <u>www.maine.gov/bhr/oeh</u> for qualifying life event list								
		Intermittent Employee		Annual Enrollment (only held in May each year; effective date of change is July 1st)								
(E.g. MCCS, MainePERS, etc.)	.g. MCCS, MainePERS, etc.)		☐ Life Event	Life Event Reason:								
and	and Retiree			Date of Life Event (required): /								
Department Name:												
		Spouse/ Dependent	_	c. Name and/or Address Change:								
(E.g. DHHS, DOT, DOC, etc.)				☐ Address Change								
(E.g. Dillio, DO1, DOC, Ctc.)	HS, DOT, DOC, etc.) Name Change Former Name											
	Date of Name Change/ Address Change (rec									uired): / /		
5a. Family Inform					gov/bhr/oeh or re	equest from yo	our human resources depa	rtment	5	b. Plan Select	tion	
			n change in coverage is nee		1 .	Doctor's Full Name and Anthem P		CP ID Number	Health	Dental Vision		
Last Name		First Name	Social Security Num	ber Date of Birth	n Gender		www.Anthem.com		Insurance	Insurance	Insurance	
Self					Male				Enroll	Enroll	Enroll	
					Female		N.		Delete	Delete	Delete	
Spouse <i>or</i> Domestic Partner					Undefined	Current Patier	nt? Yes or No		Decline	Decline	Decline	
State of Maine employee? Yes or No					Male				Enroll	Enroll	Enroll	
	_				Female Undefined		nt? ☐ Yes or ☐ No		Delete Decline	Delete Decline	Delete Decline	
(Marriage license or partner affidavit required)						Current Patier	nt? res or No		 	 	_	
Child					Male Female				Enroll	Enroll	Enroll	
(Birth certificate or court documentation required)					Female Undefined	Current Patie	nt? Yes or No		Delete Decline	Delete Decline	Delete Decline	
Child					Male	Current ratio	10.00		Enroll	Enroll	Enroll	
					Female				Delete	Delete	Delete	
(Birth certificate or court documentation required)					Undefined	Current Patier	nt? Yes or No		Decline	Decline	Decline	
I certify all information supp Wellness in accordance with dependents (if applicable) au misleading information to ar Plan's subrogation rights for revoke your consent to recei	rules, regulations & s n opportunity to apply n insurance company f my claims on a just a	statutes. I further author of for group health covera for the purpose of defrau and equitable basis. I cor	rize Employee Health & V ge that provides Minimu ding the company. My si sent to receive e-mails f	Vellness to deduct any m Value and Minimum ignature on this applic from the Office of Emp	premiums owed Essential Covera ation constitutes loyee Health & W	by me as of the ge that is affor my approval a fellness that are	e date my application is ap dable. Misrepresentation: I nd authorization for Anthe e serviced by Constant Con	proved. I understar It is a crime to knov m Blue Cross and B	nd my employer wingly provide fa lue Shield to enf	has given me an alse, incomplete force the State of	ind my e or of Maine	
•						-		have week!	ahawa			
Disclosure: By signing and d	ating this form, you n	ere by give the Office of	Employee Health and We	liness the permission	to communicate t	o you through	email to the email address	you nave provided	above.			
Signature			Date			_						
		6. Group in	formation: To be com	pleted by State of I	Maine Office of	Employee He	ealth & Wellness only					
<u>Plan Sponsor</u> : State of Maine <u>Payroll Cod</u>		Health Effective Date										
		meanth effective pate _	/					VISION ETTECTIV	on Effective Date / /			
SOM Department #:					601 State of Maine 602 Ancillary Groups: Sublocation							
Benefits Specialist:		Anthem Firm Division# 00M							Anthem Firm Division# 0VM			