Retiree Health Insurance Enrollment Form

State of Maine, Employee Health, Wellness, & Workers' Compensation, 61 State House Station, Augusta, ME 04333-0061 **Phone** (207) 624-7380 or 1-800-422-4503 www.maine.gov/bhr/oeh

Retirement Date:*_____
**Last day on payroll*
Retirement Type:
_____Service **or** _____Disability

Retiree Information

Retiree Name	Date of Birth	First Date of hire with State of Maine
Street Address	Phone Number	Department
Mailing Address (if different from above)	Social Security #	Health Policy ID #
City	State Zip Code	Health Policy Group #
Medicare Claim Number	Medicare A Effective Date	Medicare B Effective Date

Dependent Information

List dependents who are covered on your active employee health insurance. Please check YES to continue dependent coverage, or NO to end dependent coverage.

Name(s)	Relationship	Date of Birth	Social Security #	Medicare # (complete Medicare Advantage application)	Medicare A Effective Date	Medicare B Effective Date	**Continue Coverage?**	Coverage End Date
							__ Yes or __ No	
							__ Yes or __ No	
							__ Yes or __ No	

Check One

___ I will receive a monthly pension from Maine Public Employees Retirement System (MainePERS). I hereby authorize MainePERS to deduct premiums for myself (if not 100% State paid) and premiums for any dependents I cover on my health insurance policy.

___ I have elected the Lump Sum Option from MainePERS. I will be billed for my premium (if not 100% State paid) and premiums for any dependents I cover on my health insurance policy.

___ I have elected not to transfer the coverage and have signed a Request to Decline or Withdraw from Coverage Form.

___ I am not presently covered by the State of Maine Group Health Insurance Program, therefore I am not eligible.

___ I am a participant of the Maine Community College System Defined Contribution Plan.

___ I am not eligible for any State-paid contribution and elect not to carry the health insurance coverage as a retiree.

___ I am not eligible for any State-paid contribution and elect to pay 100% of the health premiums for myself and eligible dependents (if applicable)

I understand I may enroll in the State of Maine Group Health Insurance Program as a retiree member if I meet the eligibility requirements outlined in Statute. I acknowledge if I elect to delete dependents on this form, I will not be eligible to add them at a later date unless I complete a Certification for Future Enrollment form or have a qualified life event.

Retiree Signature_____ Date_____

Date First Hired: _____ **Retirement Transfer Date*_____** **For EH&B Office Use Only**

Years of Participation: _____ ***Attained Normal Retirement Age? YES _____ or NO _____** **Health Insurance Group_____**

State Premium Paid for Retiree: _____% **If No, what is Normal Retirement Age (date) _____** **EHW&WC Specialist _____**

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