STATE OF MAINE
Anthem Vision Application/Change Form
All sections need to be completed before this application can be processed.

1. Applicant Information:

Last Name	First Name	MI	Date of Birth	Social Security Number

Home Address	City	State	Zip	Home Phone: Work Phone:

Please check one:
I am currently an ☐ Active Employee OR ☐ Retiree
in department: _____

Gender:
☐ Male ☐ Female

2. Reason for Application:

☐ New Hire (Date of Hire is _____)
☐ Change Address/Name/Phone Number
☐ Cancel Coverage (Life event required; see below)
☐ Change of Coverage (e.g. add or delete spouse/dependents/domestic partner) (Life event required; see below)

3. Qualifying Life Event:

☐ Marriage – date: _____
☐ Divorce – date: _____
☐ Birth or Adoption – date: _____
☐ Leave of absence (begin/end) – date: _____
☐ Death – date: _____
☐ Involuntary Loss of Coverage – date: _____
☐ Change in Employment – date: _____
☐ Other (please specify & include date): _____

4. Applicant and Family Information:

Add/Remove	Last Name	First Name	MI	Birth Date	SSN	Gender
☐ Add ☐ Remove	Self					☐ Male ☐ Female
☐ Add ☐ Remove	☐ Spouse or ☐ Domestic Partner					☐ Male ☐ Female
☐ Add ☐ Remove	Dependent					☐ Male ☐ Female
☐ Add ☐ Remove	Dependent					☐ Male ☐ Female
☐ Add ☐ Remove	Dependent					☐ Male ☐ Female

Please sign below in either section 5 or 6

5 Applicant Signature (if you are enrolling or already enrolled):

I am requesting coverage for myself and all dependents listed and authorize my employer to deduct any required contributions for this insurance from my earnings. All statements and answers I have given are true and complete. I understand it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits. I understand all benefits are subject to conditions stated in the group agreement and Certificate of Coverage.

_____ _____
Applicant Signature Date

6. Applicant Signature (if you are NOT enrolling/CANCELLING the entire policy):

I do NOT wish to enroll in this plan and understand that the opportunity to enroll at any future date will be subject to the regulations of Anthem Vision.

_____ _____
Applicant Signature Date

Send completed form to: State of Maine, Employee Health & Benefits, 114 State House Station, Augusta, ME 04333-0114
OR fax to 287-6796 (note: If sending a fax, please do not send the original)

7. Employer Information: To be completed by Employee Health & Benefits

Employer	Group Number	Division	Effective Date
State of Maine	MS3030	V	
Action Code	**Rate Code**	**Cancel Reason Code (if applicable):**	**Initials**
A C D	0 1 2 3 4 5		