Employee Health & Benefits, 114 State House Station, Augusta ME 04333-0114
1-800-422-4503 Fax 207-287-6796
www.maine.gov/beh

State of Maine: Group Benefit Plan(s) Application/Change Form

1. Applicant Information:

Last Name	First Name	Middle	Social Security Number	Date of Birth	Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other	Sex ☐M ☐F
Mailing Address	City	State	Zip	Telephone : Work Cell	E-mail Address (optional):	

2. Employment Status:

☐ Full-Time Active Employee
☐ Part-Time Active Employee
☐ Intermittent Employee
☐ Retiree
☐ Cobra
☐ Surviving Spouse
☐ Employee On Leave

3. Reason for Application:

☐ New Hire ☐ Rehire Date _____________
☐ Life Event Reason:______________________
Date of Event: ________
☐ New Enrollment
☐ Return from Leave of Absence
Date_________
☐ Annual Enrollment
☐ Name/Address Change Date __________

4. Prior Coverage: / Other Coverage:

4a. Prior Coverage of Health Insurance: Have you or anyone on this application had health insurance coverage within the past 90 days? Y___N___ If so, whom?
Please supply us with subscriber name, Insurance Company ID #, Group # & date insurance ended:

4b. Other Group Coverage: Does anyone listed on this application have other coverage? If so, please check Y or N supply subscriber name, Insurance Company ID # Group #

Health Y ___ N ___
Dental Y ___ N ___
Vision Y ___ N ___

Medicare Y __ N __
Medicare (Claim # _ _ _ - _ _ - _ _ _ _ __
Hospital Part A Effective Date _ _ -_ _ - _ _ _ _
Medical Part B Effective Date _ _ - _ _ - _ _ _ _

5a. Family Information:						5b. Plan selection:			
Last Name	First Name	Social Security Number	Date of Birth	Sex	Medical Doctor's Name	Health Insurance In State POS	Out of State PPO	Dental Insurance	Vision Insurance
Self				☐ M ☐ F		☐ Add/Enroll ☐ Delete ☐ Decline	☐ Add/Enroll ☐ Delete ☐ Decline	☐ Add/Enroll ☐ Delete ☐ Decline	☐ Add/Enroll ☐ Delete ☐ Decline
Legal Spouse ☐ Domestic Partner ☐				☐ M ☐ F		☐ Add/Enroll ☐ Delete ☐ Decline	☐ Add/Enroll ☐ Delete ☐ Decline	☐ Add/Enroll ☐ Delete ☐ Decline	☐ Add/Enroll ☐ Delete ☐ Decline
Child				☐ M ☐ F		☐ Add/Enroll ☐ Delete ☐ Decline	☐ Add/Enroll ☐ Delete ☐ Decline	☐ Add/Enroll ☐ Delete ☐ Decline	☐ Add/Enroll ☐ Delete ☐ Decline
Child				☐ M ☐ F		☐ Add/Enroll ☐ Delete ☐ Decline	☐ Add/Enroll ☐ Delete ☐ Decline	☐ Add/Enroll ☐ Delete ☐ Decline	☐ Add/Enroll ☐ Delete ☐ Decline
Child				☐ M ☐ F		☐ Add/Enroll ☐ Delete ☐ Decline	☐ Add/Enroll ☐ Delete ☐ Decline	☐ Add/Enroll ☐ Delete ☐ Decline	☐ Add/Enroll ☐ Delete ☐ Decline

I certify that all information supplied on this form is true and complete to the best of my knowledge and/or belief. I understand that the effective date and termination date of my membership will be determined by the Division of Employee Health & Benefits in accordance with rules, regulations & statutes. I further authorize Employee Health & Benefits to deduct any premiums that are owed by me as of the date my application is approved. Misrepresentation: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company.

Signature ____ **Date** ___________

6. Group information: To be completed by Employee Health & Benefits only

Employer: **State of Maine** Department # _________ Specialist ID _________	Health Effective Date _ _/_ _/ _ _ Group # _ _ _ _ _-_ _-_ _ _	Dental Effective Date: _ _ / _ _ / _ _ __ 601 State of Maine __ 551 Other __ 602 Maine Turnpike	Vision Effective Date _ _ / _ _ / _ _ Group # _____________