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

Employee Health & Benefits, 114 State House Station, Augusta ME 04333-0114 Phone (207) 624-7380 or 1-800-422-4503 [www.maine.gov/deh](http://www.maine.gov/deh)

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| 1. **Subscriber Information** | | | | | | | | **Department Name:** | | | | | | | |
| Last Name | | | First Name | M. I. | Social Security Number | | | | | | Date of Birth | Marital Status:  Married  Single  Divorced  Widowed | | Sex  M F |
| Mailing Address | | | City | | | State | | | Zip | Telephone : Work Home Cell (207) | | | E-mail Address: | | |
| **2. Employment Status:** | | **3. Reason for Application: Required** | | | | | **4. Prior Coverage: / Other Coverage:** | | | | | | | | |
| Full-Time EE  Part-Time EE  Intermittent EE | Retiree  Surviving  Spouse  Employee  On Leave | |  |  | | --- | --- | | New Hire  Rehire  Recall from Layoff  Life Event Reason\*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Return from Leave of Absence  Annual Enrollment  Address Change  Name Change \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **If name change , former name, required**  **DATE OF HIRE OR LIFE EVENT (REQUIRED)**  **\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_**  **\*Qualifying Life events are listed on our website** | Other Group Coverage: Does anyone listed on this application have other coverage? If so, please check  Yes  No  If yes, please supply the following information:  Insurance Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Identification Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Health Y \_\_\_ N \_\_\_ Medicare Yes No  Dental Y \_\_\_ N \_\_\_ Medicare (Claim # \_ \_ \_ - \_ \_ - \_ \_ \_ \_ \_\_ ) Usually ends with a letter  Vision Y \_\_\_ N \_\_\_ Hospital Part A Effective Date \_ \_ - \_ \_ - \_ \_ \_ \_  Medical Part B Effective Date \_ \_ - \_ \_ - \_ \_ \_ \_ | | | | | | | | | | | | | | |

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| **5a. Family Information**  If you need extra space, please print another form from our website or request from your human resources department | | | | | | **5b. Plan selection** | | |
| **List only Family Members enrolling, or for whom change of status is needed** | | | | | **REQUIRED** |  | | |
| **Last Name** | **First Name** | **Social Security Number** | **Date of Birth** | **Sex** | **Physician’s Full Name and Aetna PCP Pin # (7 digits)**  **http://www.aetna.com/docfind/custom/stateofmaine/** | **Health Insurance** | **Dental Insurance** | **Vision**  **Insurance** |
| Self |  |  |  | M  F |  | Enroll  Delete  Refused | Enroll  Delete  Refused | Enroll  Delete  Refused |
| Spouse or  Domestic Partner \*\*  **\*\*required documents are on our website.** |  |  |  | M  F |  | Enroll  Delete  Refused | Enroll  Delete  Refused | Enroll  Delete  Refused |
| Child |  |  |  | M  F |  | Enroll  Delete  Refused | Enroll  Delete  Refused | Enroll  Delete  Refused |
| Child |  |  |  | M  F |  | Enroll  Delete  Refused | Enroll  Delete  Refused | Enroll  Delete  Refused |

**I certify all information supplied on this form is true and complete to the best of my knowledge and/or belief. I understand 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 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**

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| **Employer: State of Maine**  **Department #:**  **Specialist:**  **Status:** | **Health Effective Date \_ \_ / \_ \_ / \_ \_**  **CSA #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **(A E) (B G) (C I) 1 2 --- \_\_\_\_\_\_\_\_\_** | **Dental Effective Date: \_ \_ / \_ \_ / \_ \_**  **\_\_ 601 State of Maine \_\_ 551 Community Colleges**  **\_\_ 602 Maine Turnpike**  **DD01 DD02 DD03** | **Vision Effective Date \_ \_ / \_ \_ / \_ \_**    **Group # 00S \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |