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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 |

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| [ ]  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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  |