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

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:

☐ Full-Time EE ☐ Retiree

☐ Part-Time EE ☐ Surviving Spouse

☐ Intermittent EE ☐ Employee On Leave

3. Reason for Application: Required

☐ 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**

4. Prior Coverage: / Other Coverage:

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 _ _ - _ _ - _ _ _ _

5a. Family Information

If you need extra space, please print another form from our website or request from your human resources department

List only Family Members enrolling, or for whom change of status is needed

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/ (REQUIRED)	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

5b. Plan selection

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

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 _____