



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: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other			Sex <input type="checkbox"/> M <input type="checkbox"/> F	
Mailing Address		City			State	Zip	Telephone : Work		Cell	E-mail Address (optional):			

2. Employment Status:		3. Reason for Application:		4. Prior Coverage: / Other Coverage:							
<input type="checkbox"/> Full-Time Active Employee <input type="checkbox"/> Part-Time Active Employee <input type="checkbox"/> Intermittent Employee		<input type="checkbox"/> Retiree <input type="checkbox"/> Cobra <input type="checkbox"/> Surviving Spouse <input type="checkbox"/> Employee On Leave		<input type="checkbox"/> New Hire <input type="checkbox"/> Rehire Date _____ <input type="checkbox"/> Life Event Reason: _____ Date of Event: _____ <input type="checkbox"/> New Enrollment <input type="checkbox"/> Return from Leave of Absence Date _____ <input type="checkbox"/> Annual Enrollment <input type="checkbox"/> Name/Address Change Date _____		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__ Medicare Y__N__ Dental Y__N__ Medicare (Claim # _____) Vision Y__N__ 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		Dental Insurance	Vision Insurance
						In State POS	Out of State PPO		
Self				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Add/Enroll <input type="checkbox"/> Delete <input type="checkbox"/> Decline	<input type="checkbox"/> Add/Enroll <input type="checkbox"/> Delete <input type="checkbox"/> Decline	<input type="checkbox"/> Add/Enroll <input type="checkbox"/> Delete <input type="checkbox"/> Decline	<input type="checkbox"/> Add/Enroll <input type="checkbox"/> Delete <input type="checkbox"/> Decline
Legal Spouse <input type="checkbox"/>				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Add/Enroll <input type="checkbox"/> Delete <input type="checkbox"/> Decline	<input type="checkbox"/> Add/Enroll <input type="checkbox"/> Delete <input type="checkbox"/> Decline	<input type="checkbox"/> Add/Enroll <input type="checkbox"/> Delete <input type="checkbox"/> Decline	<input type="checkbox"/> Add/Enroll <input type="checkbox"/> Delete <input type="checkbox"/> Decline
Domestic Partner <input type="checkbox"/>									
Child				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Add/Enroll <input type="checkbox"/> Delete <input type="checkbox"/> Decline	<input type="checkbox"/> Add/Enroll <input type="checkbox"/> Delete <input type="checkbox"/> Decline	<input type="checkbox"/> Add/Enroll <input type="checkbox"/> Delete <input type="checkbox"/> Decline	<input type="checkbox"/> Add/Enroll <input type="checkbox"/> Delete <input type="checkbox"/> Decline
Child				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Add/Enroll <input type="checkbox"/> Delete <input type="checkbox"/> Decline	<input type="checkbox"/> Add/Enroll <input type="checkbox"/> Delete <input type="checkbox"/> Decline	<input type="checkbox"/> Add/Enroll <input type="checkbox"/> Delete <input type="checkbox"/> Decline	<input type="checkbox"/> Add/Enroll <input type="checkbox"/> Delete <input type="checkbox"/> Decline
Child				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Add/Enroll <input type="checkbox"/> Delete <input type="checkbox"/> Decline	<input type="checkbox"/> Add/Enroll <input type="checkbox"/> Delete <input type="checkbox"/> Decline	<input type="checkbox"/> Add/Enroll <input type="checkbox"/> Delete <input type="checkbox"/> Decline	<input type="checkbox"/> Add/Enroll <input type="checkbox"/> Delete <input type="checkbox"/> 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 # _____
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