



**FIREFIGHTERS AND LAW ENFORCEMENT OFFICERS  
INSURANCE SUBSIDY PROGRAM  
Application for Retirement Subsidy**

*\*Please Note: Entire form must be completed and returned regardless of choice of enrolling or not\**

Enrollment in this program is subject to the enrollment and eligibility requirements of the applicable group health plan. Eligibility for this program will be determined based on the rules and regulations that govern the program. If you have any questions, please contact the Division of Employee Health & Wellness at 1-800-422-4503. Please return form to: Department of Employee Health & Wellness, 61 State House Station, Augusta, Maine 04333-0114 or email to: Joan.M.Hanscom@maine.gov

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**Employer Section:**

Firefighter \_\_\_\_\_ Law Enforcement \_\_\_\_\_ Title of Position Held \_\_\_\_\_

NAME \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
(Please Print Clearly)

ADDRESS \_\_\_\_\_ DATE OF BIRTH \_\_\_\_ / \_\_\_\_ / \_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ PHONE \_\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_ TOTAL YEARS OF SERVICE: \_\_\_\_\_

DATE OF HIRE: \_\_\_\_\_ DATE OF RETIREMENT: \_\_\_\_\_

Is the plan participant currently enrolled with the employer's health plan? Yes \_\_\_\_\_ No \_\_\_\_\_

Date Active Health Insurance Ends: \_\_\_\_\_

Name of Employer's Health Insurance Company: \_\_\_\_\_

Which employer sponsored retirement plan does the member participate in? MainePERS \_\_\_\_\_ ICMA \_\_\_\_\_  
\_\_\_\_\_ OTHER \_\_\_\_\_  
Name of Plan

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**Employee Section:**

Please check one:

- I elect to enroll as a retiree in the Insurance Subsidy Plan and will be enrolling in my municipalities' retiree health insurance plan.
- I currently have health insurance coverage through my spouse and elect to have the insurance Subsidy contributions made towards this plan. Documentation required. Contact Office of EH & B for more information at 207-624-7682.
- I elect to enroll in the State of Maine retiree health insurance plan if applicable to my municipality
- I elect NOT to enroll in the Insurance Subsidy Plan because I have coverage thru my new employer. I understand that future enrollment as a retiree may not be allowed. Contact office of EH & B for more information.
- Retiree return to work – Special re-enrollment provisions apply

By signing below, I certify that all information supplied on this form is true and accurate to the best of my knowledge. I also give my authorization to the Division of Employee Health & Wellness to obtain all information necessary to comply with the rules, regulations and statutes that govern the Retired Fire Fighters and Law Enforcement Officers Insurance Subsidy Program.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

EH&B Use Only: Eligible for subsidy YES \_\_\_\_\_ NO \_\_\_\_\_ Not eligible for subsidy - Reason \_\_\_\_\_ Date \_\_\_\_\_  
Retirement Subsidy App. REV. 7/2022