



State of Maine: Group Benefit Plans Enrollment/Change Form

Employee Health & Wellness, 61 State House Station, Augusta ME 04333-0061 e-mail: info.benefits@maine.gov phone: (207)624-7380 or 1-800-422-4503 www.maine.gov/bhr/oe



1. Subscriber Information
Last Name, First Name, M. I., Social Security Number, Date of Birth, Marital Status, Gender
2. Employer/Department: Working for or retired from: Employer: State of Maine, Other
3. Current Employment Status: Check one below: Active Employee, Intermittent Employee, Retiree, Surviving Spouse/ Dependent
4. Reason for Application: (Required)
a. Change in Employment: New Hire, Rehire, Return from Leave of Absence, Recall from Layoff
b. Qualifying Life Event: Documentation required. Annual Enrollment, Life Event Reason
c. Name and/or Address Change: Address Change, Name Change

5a. Family Information
List only family members enrolling, or for whom change in coverage is needed
Last Name, First Name, Social Security Number, Date of Birth, Gender, Doctor's Full Name and Anthem PCP ID Number
5b. Plan Selection
Health Insurance, Dental Insurance, Vision Insurance

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 Office of Employee Health & Wellness in accordance with rules, regulations & statutes.

Disclosure: By signing and dating this form, you hereby give the Office of Employee Health and Wellness the permission to communicate to you through email to the email address you have provided above.

Signature _____ Date _____

6. Group information: To be completed by State of Maine Office of Employee Health & Wellness only

Plan Sponsor: State of Maine
Payroll Code
Health Effective Date, Dental Effective Date, Vision Effective Date
SOM Department #:
Anthem Firm Division# 00M
Benefits Specialist:
DD01 DD02 DD03
Anthem Firm Division# OVM