STATE OF MAINE
DEPARTMENT OF ADMINISTRATIVE & FINANCIAL SERVICES
Bureau of Human Resources
Office of Employee Health and Wellness
61 State House Station
Augusta, ME 04333-0061

Janet T. Mills, Governor
Kirsten LC Figueroa, Commissioner

EMPLOYEE ELECTION TO CANCEL HEALTH INSURANCE

Employee Name:_____

Social Security Number:_____Date of Birth:_____

Address:.....

Phone Number:_ _ _ _ _ _ _ _ _ _ Department Name:_____

Health Plan ID#:_ _ _ _ _ _ _ _ _ _ Group#_____

I am requesting cancellation of my health insurance plan under the Maine State Employees Health Insurance Program for the following reason:

___ Change in hours - Full time to Part time within the past 60 days.

___ Commencement of other health insurance coverage within the past 60 days.

___ My contribution level has increased within the past 60 days and I do not wish to pay the additional premium.

___ Annual Enrollment

___ Other (Provide specific qualifying life event to determine eligibility. The list of qualifying life events can be viewed on our website at www.maine.gov/bhr/oeh) _____

_____

By signing this document:

- I understand if I plan to retire from the State of Maine or any of its Ancillary Group Employers covered by the Maine State Employees Health Insurance Program and wish to have health insurance benefits as a retiree, I must be enrolled for one full year immediately prior to retirement; AND
- Any State or employer contribution towards that benefit depends upon my first employment date and the number of years I was enrolled as an employee in the health insurance plan.

_____ _____
Signature Date

Mail completed form to Employee Health & Wellness, 61 State House Station, Augusta, Maine 04333-0061 or e-mail to Info.Benefits@Maine.gov.

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