# MEA Benefits Trust
# Application for Transfer of the Health Plan to Retirement Status

Anthem BlueCross BlueShield

**Please return this form to your employer** – If you are now retired, please mail this form to:
Anthem Blue Cross and Blue Shield, Enrollment and Billing, 2 Gannett Drive, South Portland, ME 04106.

If you have any questions about this form, call Anthem at 888-399-8706, ext. 1.

**Please print.**

**SECTION 1: APPLICANT INFORMATION – Dependent coverage is only available to those members now covered on your policy**

| Check plan: ☐ Single ☐ 2 person ☐ Family ☐ Adult with child or children | Group no. |
|---|---|

**EMPLOYEE INFORMATION**

| School department | Occupation | Identification no. |
|---|---|---|
| | | |

**RETIREE INFORMATION**

| Last name | First name | M.I. | Birthdate | Social Security no. |
|---|---|---|---|---|
| | | | | |

| Phone no. | Street address | City | State | ZIP code |
|---|---|---|---|---|
| | | | | |

**LEGAL SPOUSE OR DOMESTIC PARTNER INFORMATION – Complete only if legal spouse or domestic partner is eligible for coverage**

| Last name | First name | M.I. | Birthdate | Social Security no. |
|---|---|---|---|---|
| | | | | |

**SECTION 2: DELETE DEPENDENTS – Deleted dependents will not be eligible to re-enroll**

| Name | Birthdate | Social Security no. | Reason* | Effective date |
|---|---|---|---|---|
| Spouse or domestic partner | | | | |
| Dependent – oldest first | | | | |
| Dependent | | | | |
| Dependent | | | | |

***Reason**: A. Marriage B. Divorce C. Separation D. Death E. Entered military service F. Medicaid or state assistance
G. Has own Anthem contract H. Other insurance: _____ I. Other: _____

**SECTION 3: MEDICARE ELIGIBLE – To be eligible for Medicare supplemental coverage you must have both Medicare Parts A and B. If you are age 65 or older and not eligible for Medicare, include a copy of your Social Security ineligibility letter.**

| Name(s) of Medicare beneficiaries | | | Medicare claim no. | Medicare Part A effective date month/day/year | Medicare Part B effective date month/day/year | Check all reasons you qualified for Medicare | | |
|---|---|---|---|---|---|---|---|---|
| Last name | First name | M.I. | | | | Age 65 | Disability | ESRD* |
| | | | | | | ☐ | ☐ | ☐ |
| | | | | | | ☐ | ☐ | ☐ |
| | | | | | | ☐ | ☐ | ☐ |

*End Stage Renal Disease

| **FOR SCHOOL USE ONLY** | MainePERS employer code | Position class code | Termination from active group | Date health insurance ends | Signature of school official |
|---|---|---|---|---|---|
| | | | | | |

## SECTION 4: MAINEPERS RETIREES

If you retired through the Maine Public Employees Retirement Systems (MainePERS) after July 1, 2012, Maine State law now requires you to be of "normal retirement age" to be eligible for the State of Maine contribution toward your health insurance. To ensure that you receive the State of Maine contribution to which you may be entitled, you are required to notify Anthem on reaching "normal retirement age." Please contact MainePERS with any questions pertaining to "normal retirement age."

If you are eligible for the State of Maine contribution toward retired teachers' health insurance premium, your health insurance premium must be deducted from your MainePERS pension check.

- ☐ I hereby authorize the MainePERS to deduct the proper amount to cover the cost(s) of my Anthem health coverage.
- ☐ I am at my "normal retirement age."
- ☐ I am not at my "normal retirement age."
- ☐ I have elected not to transfer the Anthem health coverage.
- ☐ I am applying for Disability Retirement:
  - ☐ Bill me directly
  - ☐ Deduct the Anthem health premium out of my MainePERS pension check
- ☐ Please bill me directly for Anthem health coverage.
- ☐ Please continue my coverage as a surviving spouse/domestic partner/dependent:
  - ☐ Bill me directly
  - ☐ Deduct the Anthem health premium out of my survivor MainePERS pension check
- ☐ I have 25 years of creditable service (in compliance with L.D. 1955) under MainePERS and wish to make a one-time election to defer my health insurance effective: ____/____/____
- ☐ Returning from Creditable Service Break (in compliance with L.D. 1955) effective: ____/____/____

**MEA Benefits Trust Break Provision**: If a participant is eligible to continue coverage, he or she shall be entitled to one break in coverage, lasting no longer than five (5) years or until reaching age 62, whichever occurs first. Other restrictions apply. For more information, please contact the MEA Benefits Trust at 888-622-4418, ext. 2207 or Anthem at 888-399-8706, ext. 1.

- ☐ Applying for the MEA Benefits Trust break provision effective: ____/____/____
- ☐ Returning from the MEA Benefits Trust break provision effective: ____/____/____

## SECTION 5: SIGNATURE REQUIRED

I have been advised that **if at the time of retirement I am covered by the MEA Benefits Trust group health plan and meet the applicable requirements**, I may request transfer of my health coverage to retirement status. That part of the monthly premium for which I am responsible will be deducted from my retirement benefit check (if applicable). If retiring on a disability retirement, I authorize the MainePERS to withhold the amount of any health insurance premium which the MEA Benefits Trust/Anthem certifies to the System is owed by me as of the date on which my disability retirement is approved (if applicable). **I understand that in so doing, the MainePERS is acting as the agent of the MEA Benefits Trust**; any dispute as to this withholding is to be addressed to the MEA Benefits Trust/Anthem (if applicable). ***I also acknowledge that if I elected to delete dependents on this form, I will not be eligible to re-add them at a later date under the retiree group.***

I have been advised that part of the monthly premium for which I am responsible will be deducted from my retirement benefit check (if applicable). All statements and answers I have given are true and complete. I understand it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. I understand all benefits are subject to conditions stated in the group agreement and Certificate of Coverage.

If MEA Choice Plus is chosen, I understand that each family member's care must be provided or arranged by his/her Primary Care Physician (PCP) except as described in my Certificate of Coverage.

**L.D. 1955 An Act to Amend the Health Insurance Benefits of State Employees and Teachers Who Retire or Terminate Service.**

This law 1) allows a state employee or teacher member who has at least 25 years of creditable service and who on or after January 1, 1999 terminates employment under which the member was eligible for the group health plan but does not retire at that time, to make a one-time election to continue coverage from the date of termination until retirement by paying the cost of coverage plus any administrative cost; and 2) allows a state employee or teacher member who has at least 25 years of creditable service and who on or after January 1, 1999 retires but who is not in service immediately prior to retirement to make a one-time election at retirement to rejoin the group health plan.

In signing this application I certify that I have read and understand all the information on **both** sides of this form.

| Applicant signature | Date |
|---|---|
| **X** | |