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

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 Blue Cross and Blue Shield (Anthem) at: 888–399–8706

Please complete electronically or print legibly using black ink.

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 — If Rehired Retiree, use original school you retired from.

School department	Occupation	Anthem member ID no.
Current email address (other than your school email)		

Retiree Information

Last name	First name	M.I.	Birthdate (MMDDYYYY)	Social Security no.

Phone no.	Street address	City	State	ZIP code

Complete only if legal spouse, domestic partner, or dependent is eligible for coverage.

Last name	First name	M.I.	Birthdate (MMDDYYYY)	Social Security no.

Section 2: Delete dependents — Deleted dependents will not be eligible to re–enroll.

Name	Birthdate (MMDDYYYY)	Social Security no.	Reason	Effective date (MMDDYY)
Spouse or domestic partner				
Dependent — oldest first				
Dependent				
Dependent				

Section 3: Medicare eligible — To be eligible for Medicare Advantage coverage you must have both Medicare Parts A and B. If you are age 65 or older and not eligible for premium–free Medicare, include a copy of your Social Security ineligibility letter.

Name(s) of Medicare covered person(s)			Medicare number	Medicare Part A effective date (MMDDYY)	Medicare Part B effective date (MMDDYY)	Check all reasons you qualified for Medicare		
Last name	First name	M.I.				Age 65	Disability	ESRD*
						☐	☐	☐
						☐	☐	☐
						☐	☐	☐

* End Stage Renal Disease

Required information prior to sending to Anthem

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 law generally requires you to reach "normal retirement age" before you can begin to receive the State of Maine contribution toward your health insurance. Your "normal retirement age" will be determined by your dates of service. 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" as it applies to you. 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.

Please check one of the following:

- ☐ I have reached my "normal retirement age" as of: ____ (MMDDYYYY)
- ☐ I have not reached my "normal retirement age."

☐ I have elected not to transfer the Anthem health coverage.

☐ I am applying for Disability Retirement: ☐ I have been approved for Disability Retirement as of: ____ (MMDDYYYY)

- ☐ 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, was not in service immediately prior to retirement, and am now making a one–time election to rejoin the plan at the time of my retirement, as allowed by 20–A Me. Rev. Stat § 13451(2–C).

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.

☐ Applying for the MEA Benefits Trust break provision effective: ____ (MMDDYYYY)

☐ Returning from the MEA Benefits Trust break provision effective: ____ (MMDDYYYY)

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 the portion 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.

My signature on this application constitutes my approval and authorization for Anthem to enforce its subrogation rights for my claims on a just and equitable basis.

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

Applicant signature	Date (MMDDYYYY)
X	

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