STATE OF MAINE

Anthem Vision Application/Change Form 001

1. Reason for Application: To be completed by Employee/Retiree

☐ New Application ☐ Change of Coverage ☐ Change Address/Name/Phone Number	Qualifying Event:____________ _____ Date of Event: ___________________

2. Applicant Information:

Last Name	First Name	MI	Date of Birth	Social Security Number

Home Address	City	State	Zip	Home Phone: Work Phone:

Date of Hire: (Active employees only)	Hrs Worked Per Wk	Gender:	☐ Active Employee or ☐ Retiree

3. Family Information: (list only family members you wish to enroll, remove, change or those dependents who are affected by the Qualifying Event noted above in Section 1)

You may apply to cover your legal spouse, domestic partner (a completed Affidavit of Domestic Partnership must be attached to this application) and unmarried children and stepchildren under 19 years of age. You may also apply to cover some children and stepchildren 19 and older if they are unmarried and more than 50% dependent on you.

Add/Remove	Last Name	First Name	MI	Date of Birth	SSN	Gender
☐ Add ☐ Remove	Self					
☐ Add ☐ Remove	☐ Spouse or ☐ Domestic Partner					
☐ Add ☐ Remove	Dependent					
☐ Add ☐ Remove	Dependent					
☐ Add ☐ Remove	Dependent					

4. Applicant Signature:

I am requesting coverage for myself and all dependents listed and authorize my employer to deduct any required contributions for this insurance from my earnings. 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 denial of insurance benefits. I understand all benefits are subject to conditions stated in the group agreement and Certificate of Coverage.

_________________________________ Applicant   _______________ Date

5. Election NOT to Enroll:

I do NOT wish to enroll in this plan and understand that the opportunity to enroll at any future date will be subject to the regulations of Anthem Blue Cross and Blue Shield.

_________________________________ Applicant   _______________ Date

Send completed form to: State of Maine, Employee Health & Benefits, 114 State House Station, Augusta, ME 04333-0114 OR via fax to 287-6796*

***If sending via fax, do not send original copy.**

6. Employer Information: To be completed by Employer

Employer	Group Number	Division	Effective Date
State of Maine	MS3030	V______	