

**MAINE MUNICIPAL EMPLOYEES HEALTH TRUST**  
**EMPLOYER STATEMENT REGARDING**  
**RETIREE ELIGIBILITY FOR**  
**CONTINUED HEALTH INSURANCE**

Employee Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employee ID #: \_\_\_\_\_ Date of Retirement: \_\_\_\_\_

YES \_\_\_\_\_ NO \_\_\_\_\_

1. Has the employee been employed by, or been an elected or appointed official with, this employer for the last five (5) consecutive years?

YES \_\_\_\_\_ NO \_\_\_\_\_

2. On the date of retirement was the employee at least 55 years old?

YES \_\_\_\_\_ NO \_\_\_\_\_

3. Is the employee receiving benefits from a retirement plan established by **this** employer (i.e. Maine Public Employees Retirement System or ICMA)?

This form must be completed and sent in with your bill, payment and termination form.

\_\_\_\_\_  
Name of Employer

\_\_\_\_\_  
Signature of Employer Representative

\_\_\_\_\_  
Date