AETNA VISION PREFERRED ENROLLMENT / CHANGE FORM

Plan year July 1, 2024 – June 30, 2025

Monthly Vision Premium: Retiree - $4.86 Retiree + 1 - $7.78 Family - $12.66
Please note monthly premium amount will be deducted automatically from your MainePERS pension.

Subscriber Information

Last Name, First Name, Middle Initial: _____

Date of Birth (MM/DD/YYYY): _____ SSN: _____ Gender (M/F) _____

Home Address: _____ Apartment Number: _____

City, State, Zip Code: _____

Preferred Phone Number: _____ Email: _____

Date of Enrollment/Change: _____

Reason Enrollment/Change:

ADD:	**DELETE:**
Open Enrollment _____	Open Enrollment _____
Marriage _____	Employment Change _____
Employment Change _____	Divorce _____
Adoption/Birth _____	Deceased _____
COBRA Ending _____	Not Dependent (IRS) _____

Individuals Covered (List individuals whom you are enrolling or adding to Vision Coverage)

Spouse/Domestic Partner - Last Name, First Name, Middle Initial: _____
Sex (M/F): ___ Date of Birth (MM/DD/YYYY): _____
Other Dependent - Last Name, First Name, Middle Initial: _____
Sex (M/F): ___ Date of Birth (MM/DD/YYYY): _____

Retiree Signature

Statements made in this document are deemed to be representations and not warranties. I represent that all information is true and correct to the best of my knowledge. I understand that by not choosing a network provider for myself or any family member, I may be responsible for higher out of pocket expenses. I also understand that the effective date and termination date of my membership will be determined by MAR. I understand that my dependents and I must remain enrolled and can discontinue our coverage only during open enrollment, except in the event of a qualified family status change. By signing above, I hereby accept coverage. **Please return this form to MAR, 157 Capitol St., Suite 4, Augusta, ME 04330 or email the form to MAR@MaineRetirees.org Contact MAR: (800) 535-6555 or (207) 582-1960**