

STATE OF RHODE ISLAND & PROVIDENCE PLANTATIONS

Department of Administration – Office of Employee Benefits Phone: (401) 574-8530 Fax: (401) 574-9281



HEALTH COVERAGE ENROLLMENT / STATUS CHANGE FORM

☐ New Hire ☐ Open Enrollment ☐ Qualified Status Change ☐ Name/Address Change						
1. EMPLOYEE INFORMATION – Please print clearly and legibly. ALL FIELDS REQUIRED						
NAME:				HIRE DATE:		
First MI Last MAILING ADDRESS: PHONE:						
Street	City	State	Zip			
EMAIL ADDRESS:						
MARITAL STATUS: Single Married Divorced Domestic			DOB:	OB: SEX: M F		
2. QUALIFIED STATUS CHANGE Supporting documentation must be submitted for all status changes within 31 calendar days of the occurrence of						
Event Date: the status change event.						
☐ Marriage ☐ Domestic partnership begins/ends ☐ Divorce ☐ Death ☐ Birth/Adoption ☐ Loss of coverage						
Change from full-time to part- Commencement or return from Employment begins or ends Compliance with certain						
time employment or vice versa for an unpaid leave of absence for you or open enrollment period for domestic relations orders or you or spouse/domestic partner or spouse/domestic partner spouse/domestic partner decrees						
3. MEDICAL/Rx COVERAGE ELECTION – Choose 3A or 3B below. You must attach the Medical Waiver Form if waiving medical/Rx coverage. You						
-	attach the Optum Bank HSA				~	reruger rou
3A. 2014 ACTIVE EMPLOYEES HEALTH PLAN CHOICE PLUS						
☐ Enroll ☐ Change ☐ Waive ☐ No Change ☐ Individual Plan ☐ Family Plan (Must complete Section 6 Dependent Info)						
3B. CHOICE PLUS PLAN WITH HEALTH SAVINGS ACCOUNT (HSA)						
Enroll Change Waive No Change Individual Plan Family Plan (Must complete Section 6 Dependent Info) 4. DENTAL COVERAGE ELECTION – DELTA DENTAL OF RHODE ISLAND						
Enroll Change Waive No Change Individual Plan Family Plan (Must complete Section 6 Dependent Info) 5. VISION COVERAGE ELECTION – VISION SERVICE PLAN (VSP)						
Enroll Change Waive No Change Individual Plan Family Plan (Must complete Section 6 Dependent Info)						
6. DEPENDENT INFORMATION — Copy of marriage certificate must be attached to add any spouse. Completed Affidavit of Domestic Partnership and Domestic Partner Dependent Declaration Form must be attached to add any domestic partner. Copy of birth certificate must be attached to add any dependent child.						
Check One:				Sex	Birth Date	Full Time
roll Drop Name (First, MI, Last)		Relation*	Dependent SSN	M/F	MM/DD/YY	Student**
*Relationship: S =Spouse C =Child DP =Domestic Partner **Proof of full time student status required for dental and vision coverage for any dependent child between ages 19 and 25.						
7. DUAL STATE-EMPLOYED SPOUSES DECLARATION – Are both you and your spouse state employees?						
8. EMPLOYEE APPROVAL AND AUTHORIZATION – Please read and sign below.						
I certify that the above information is true and correct to the best of my knowledge. I understand that my elections are irrevocable during the plan year and that I can only change my election(s) during open enrollment or within 31 days of a qualified status change. I authorize the deduction of the appropriate co-shares from my wages, and agree that should I have an unpaid leave of absence from my employment I shall be responsible for direct remittance of my co-share payments or risk termination of my coverage with 30 days' notice. Should I return from a leave of absence with an unpaid co-share debt, I authorize my employing agency to deduct the balance of my debt through additional payroll deductions over time in amounts not exceeding my standard co-share deduction amount per pay period. Should I leave state service with an unpaid co-share debt, I authorize my employing agency to deduct the balance of my debt from any accrued vacation and/or sick time pay out.						
Employee Signature: Date:						
The Rhode Island State Employee Health Plan complies with Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Language assistance services, free of charge, are available to you. Call (401) 574-8530.						
TO BE COMPLETED BY AGENCY HR STAFF:						

FT/PT: _____ Annual Salary: _____ Union Code: _____ Payroll Account Number: ____