



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: SSN: HIRE DATE: MAILING ADDRESS: PHONE: EMAIL ADDRESS: MARITAL STATUS: SEX: M F

2. QUALIFIED STATUS CHANGE Supporting documentation must be submitted for all status changes within 31 calendar days of the occurrence of the status change event.

Event Date: ☐ Marriage ☐ Domestic partnership begins/ends ☐ Divorce ☐ Death ☐ Birth/Adoption ☐ Loss of coverage

3. MEDICAL/Rx COVERAGE ELECTION – UNITEDHEALTHCARE/CVS CAREMARK Choose 3A or 3B below. You must attach the Medical Waiver Form if waiving medical/Rx coverage.

3A. 2014 ACTIVE EMPLOYEES HEALTH PLAN CHOICE PLUS ☐ Enroll ☐ Change ☐ Waive ☐ No Change ☐ Individual Plan ☐ Family Plan

3B. CHOICE PLUS PLAN WITH HEALTH SAVINGS ACCOUNT (HSA) ☐ Enroll ☐ Change ☐ Waive ☐ No Change ☐ Individual Plan ☐ Family Plan

4. DENTAL COVERAGE ELECTION – DELTA DENTAL OF RHODE ISLAND ☐ Enroll ☐ Change ☐ Waive ☐ No Change ☐ Individual Plan ☐ Family Plan

5. VISION COVERAGE ELECTION – VISION SERVICE PLAN (VSP) ☐ Enroll ☐ Change ☐ Waive ☐ No Change ☐ Individual Plan ☐ Family Plan

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.

Table with columns: Check One (Enroll, Drop), Name (First, MI, Last), Relation\*, Dependent SSN, Sex M/F, Birth Date MM/DD/YY, Full Time 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? ☐ Y ☐ N If you checked the "Y" box, you must complete and attach the Dual State-Employed Spouses Declaration Form.

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.

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.

TO BE COMPLETED BY AGENCY HR STAFF:

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