State of Rhode Island & Providence Plantations
DEPARTMENT OF ADMINISTRATION
Office of Employee Benefits
Phone: (401) 222-3160 Fax: (401)222-2964

UNION CODE _____

HEALTH INSURANCE ENROLLMENT / STATUS CHANGE FORM

☐ **New Hire** ☐ **Open Enrollment** ☐ **Qualified Status Change** ☐ **Address Change**

Effective Date: ____ / ____ / _____ **Payroll Account No: _____**

1. EMPLOYEE INFORMATION: *Please Print*

NAME: (First MI Last) | SSN: | HIRE DATE:

ADDRESS: (Street City State Zip) | PHONE: ( )

MARITAL: ☐ S ☐ M ☐ D ☐ Domestic Partner ☐ Civil Union | DOB: | SEX: ☐ M ☐ F

2. QUALIFIED STATUS CHANGE: ***Supporting documentation must be submitted for all status changes within 31 calendar days (except for Marriage which is 60 calendar days).***

☐ Marriage /Civil Union ☐ Domestic Partner ☐ Divorce ☐ Death ☐ Birth/Adoption ☐ Loss of Coverage

☐ Change from full-time to part-time employment or vice versa for you or spouse ☐ Spouse's Employment Begins or Ends or Open Enrollment ☐ Compliance with certain Family Relations Order or Decrees

3. MEDICAL COVERAGE INFORMATION – UNITEDHEALTHCARE (UHC)

☐ Enroll ☐ Change ☐ Waive *(Medical Waiver Form must be attached)* | ☐ Individual Plan ☐ Family Plan *(Must complete Section 6 Dependent Info)*

4. DENTAL COVERAGE INFORMATION - DELTA DENTAL OF RHODE ISLAND (DD)

☐ Enroll ☐ Change ☐ Waive | ☐ Individual Plan ☐ Family Plan *(Must complete Section 6 Dependent Info)*

5. VISION COVERAGE INFORMATION – VISION SERVICE PLAN (VSP)

☐ Enroll ☐ Change ☐ Waive | ☐ Individual Plan ☐ Family Plan *(Must complete Section 6 Dependent Info)*

6. DEPENDENT INFORMATION: *Copy of birth certificate must be attached to add any dependent child.*

Check One Enroll	Check One Drop	Name (First, MI, Last)	Relation*	Dependent SSN	Sex M/F	Birth Date MM/DD/YY	Full Time Student**
☐	☐						☐
☐	☐						☐
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***Relationship:** **S**=Spouse **C**=Child **DP**=Domestic Partner
**Proof of full time student status required for dental and vision coverage.

7. DUAL COVERAGE:

Does your spouse work for the state? ☐ Y ☐ N | If yes, does he/she have family coverage? ☐ yes *(Fill out information below)* ☐ no

Spouse's Name: Spouse's SSN:

8. EMPLOYEE APPROVAL AND AUTHORIZATION:

I authorize the deductions of the appropriate co-share from my wages, and understand it is my responsibility to verify that the correct co-share amount is deducted. In addition, I certify that the above information is true and correct to the best of my knowledge and understand that, by law, I can only change my election(s) during Open Enrollment or when I have a qualified status change as defined by section 125 IRS status change rules and I submit the required documentation within 31 days of the change (except for marriage, which is 60 days.)

Employee Signature: Date:

OFFICE USE ONLY
Processed by Benefits Office: Processed by Payroll Office:

State of Rhode Island
DEPARTMENT OF ADMINISTRATION
Office of Employee Benefits
One Capitol Hill, Providence RI 02908
Phone: (401) 222-3160 Fax: (401)222-2964

Health Insurance Enrollment Form Instructions

Use the *Health Insurance Enrollment Form* to add, drop, or change medical, dental, and/or vision coverage for employees and dependents. If you have other health insurance coverage and choose to waive the state health plan to receive the $1,001/year payment, submit the *Waiver of Medical Insurance Form*. All forms are available at www.employeebenefits.ri.gov.

DOCUMENTATION REQUIRED FOR ALL ENROLLMENTS: *Supporting evidence for all enrollments must be attached to the Enrollment Form and forwarded to the Office of Employee Benefits*. Forms will not be processed until the required documentation is received.

NEW EMPLOYEES:

Health insurance elections must be made within 31 calendar days after hire date by submitting the *Health Insurance Enrollment Form* to the Office of Employee Benefits. Per federal regulation, social security numbers are required for all dependents listed on the enrollment form.

Marriage:
Employees must attach a copy of their marriage certificate to the *Health Insurance Enrollment Form* in order to enroll a spouse for medical, dental, or vision insurance coverage.

Common Law Marriage:
Employees must submit the *Affidavit of Common Law Marriage* and supporting documentation with the *Health Insurance Enrollment Form*.

Civil Unions:
To enroll a civil union spouse or children of a civil union spouse, employees must provide a copy of their civil union certificate, complete the *Certification of Tax Dependent Status for a Civil Union Spouse/Children Form,* and attach both to the *Health Insurance Enrollment Form*.

Domestic Partnership and Civil Union Coverage:
A *Domestic Partner Dependent Declaration Form* and an *Affidavit of Domestic Partnership Form* with supporting documentation must be attached to the Health Insurance Enrollment Form to enroll a domestic partner.

Children:
Employees must attach a copy of their child's birth certificate to the *Health Insurance Enrollment Form* in order to enroll a child for medical, dental or vision insurance coverage.

Children Age 19 – 26: Medical Coverage: Medical coverage is available for children up to the end of the month they reach age 26, provided they do not have access to medical insurance through their employer.

Children Age 19 – 25: Dental and Vision Coverage:
You must submit a copy of a current tuition bill or a letter from the school's registrar showing proof of full-time student status (12+ credits per semester) at an accredited post-secondary school, college, university or trade school. Dental and vision coverage is only available up to the end of the year that dependent children who are full-time students reach age 25.

Handicapped Dependent:
A *Statement of Dependent Eligibility Due to Mental or Physical Handicap* must be completed by both the employee and the dependent's physician and submitted to the Office of Employee Benefits for a determination of eligibility. Coverage will not be effective until the completed *Statement of Dependent Eligibility Due to Mental or Physical Handicap* is reviewed and accepted by the Office of Employee Benefits.

STATUS CHANGE:

Employees must submit the *Health Insurance Enrollment Form*, along with the required supporting documentation categorized above, within 31 calendar days to make coverage changes due to a "status change." Eligible "status change" events include:

- the birth/adoption of a child
- change of employment from full-time to part-time
- spouse's employment begins/ends/open enrollment
- compliance with certain Family Relations Orders
- marriage / civil union
- loss of other health insurance
- death
- divorce
- domestic partnership

Note: Employees are permitted 60 calendar days after a marriage or civil union to add a new spouse.

If the *Health Insurance Enrollment Form* is not received within the required timeframe, employees must wait until the next open enrollment to make any changes.

Please staple all forms and supporting documentation together when submitting paperwork to the Office of Employee Benefits.