State of Rhode Island & Providence Plantations
DEPARTMENT OF ADMINISTRATION
Office of Employee Benefits
Phone: (401) 222-3160 Fax: (401)222-6391

WAIVER OF MEDICAL COVERAGE FORM

EMPLOYEE INFORMATION **(Please Print)**

Name: _____ **SS#:** _____

Payroll Account #: _____ **Date of Hire:** _____

State Agency: _____ **Home Phone:** _____

Employee Address: _____
Street City State Zip Code

☐ **WAIVER of Medical Insurance Coverage**

Effective Date of Waiver
(beginning of payroll period): _____

I understand that by signing and submitting this election form, I acknowledge that I have other medical coverage and am making a binding election to waive State of Rhode Island sponsored medical coverage for myself and my dependents. In lieu of the State of Rhode Island medical coverage, I understand that my taxable pay shall be increased by an annualized amount of $1,001 a year (accrued at the rate of $38.50 per pay period) or such amount as the State shall determine in future periods. Such increase in pay shall not be taken into account in calculating my other State of Rhode Island benefits that are pay related.

This waiver will continue to be effective until such time in the future when/if I choose to elect medical insurance coverage. I understand that the only time I am able to elect health insurance coverage through the State is during the annual open enrollment period or if I have a change in status such as marriage, divorce, death of a spouse or child, birth or adoption of a child, termination of employment of a spouse, material change in the spouse's health benefits or such other events as the Plan Administrator determines is applicable by law. In case of a changing family status, I must provide proof of the change.

REQUIRED INFORMATION

Identification of my other health coverage:

Name of other employer: _____
Name of other insurer or HMO: _____
Name of Alternate Policy Holder: _____
Plan or Group Identification No. (from ID card): _____

☐ **RESCIND Waiver**

Effective Date of Coverage Begins
(beginning of payroll period): _____

I understand that by signing and submitting this form, I rescind my prior election to waive the State of Rhode Island medical coverage. Therefore, if otherwise eligible, I shall now be covered by the State of Rhode Island medical coverage for myself and my eligible dependents. At the same time that I become covered by the State of Rhode Island medical plan, the State will cease accruing my "opt-out-bonus" of $1,001 per year prorated for the number of pay periods ($38.50 per pay period) from which such election applies.

I acknowledge that I cannot change this election except at open enrollment unless I have a change in status such as those listed above.

Employee Signature: _____ **Date:** _____

OFFICE USE ONLY

Accepted by: Date Received: _____