**STATE OF RHODE ISLAND & PROVIDENCE PLANTATIONS**
Department of Administration – Office of Employee Benefits
One Capitol Hill – 3rd Floor, Providence, RI 02908
Phone: (401) 574-8530 Fax: (401) 574-9281

# GROUP LEGAL CARE PAYROLL DEDUCTION AUTHORIZATION FORM

◯ **New Hire (Date of hire: _____ )** ◯ **Open Enrollment**

*You may only add or drop group legal coverage within 31 days of your initial hire date or during the open enrollment period. Your elected coverage will remain in place as long as you do not take any additional action.*

## 1. EMPLOYEE INFORMATION *If handwritten, please print clearly and legibly*

NAME: _____
First MI Last

SSN:

## 2. COVERAGE ELECTION

◯ Individual
($3.11 biweekly premium)

◯ Family
($4.78 biweekly premium)

◯ Cancel coverage

## 3. EMPLOYEE APPROVAL AND AUTHORIZATION:

I hereby authorize the State of Rhode Island to deduct the applicable premium from my wages.

Employee Signature: _____ Date: _____

**TO BE COMPLETED BY AGENCY HR STAFF:**

Union Code: _____ Payroll Account Number: _____