



STATE OF RHODE ISLAND & PROVIDENCE PLANTATIONS

Department of Administration – Office of Employee Benefits

Phone: (401) 222-3160 Fax: (401) 222-2964



HEALTH COVERAGE ENROLLMENT / STATUS CHANGE FORM

☐ New Hire ☐ Open Enrollment ☐ Qualified Status Change ☐ Name/Address Change

1. EMPLOYEE INFORMATION – Please print clearly and legibly.

NAME: SSN: HIRE DATE: ADDRESS: PHONE: () MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Domestic Partnership DOB: 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. See form instructions for further information on status changes and effective dates.

Event Date: ☐ Marriage ☐ Domestic partnership begins/ends ☐ Divorce ☐ Death ☐ Birth/Adoption ☐ Loss of coverage ☐ Change from full-time to part-time employment or vice versa for you or spouse/domestic partner

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. You must attach the Optum Bank HSA Application if enrolling in the Choice Plus Plan with HSA.

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.

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. Language assistance services, free of charge, are available to you. Call (401) 222-3160.

TO BE COMPLETED BY AGENCY HR STAFF: Union Code: Payroll Account Number: