STATE OF RHODE ISLAND & PROVIDENCE PLANTATIONS

Department of Administration – Office of Employee Benefits

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

WAIVER OF MEDICAL/PHARMACY COVERAGE FORM

EMPLOYEE INFORMATION **(Please Print)**

Name: ______________________ **SSN:** ______________________

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

State Agency: Community College of Rhode Island **Phone:** ______________________

Employee Address: ____

Street City State Zip Code

☐ **WAIVER of Medical/Pharmacy 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/pharmacy coverage and am making a binding election to waive state-sponsored medical/pharmacy coverage for myself and my dependents. In lieu of medical/pharmacy coverage under the state employee health plan, 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 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/pharmacy coverage under the state employee health plan. I understand that the only time I am able to elect state employee health plan coverage is during the annual open enrollment period or if I experience a qualifying status 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 state-sponsored medical/pharmacy coverage. Therefore, if otherwise eligible, I shall now receive medical/pharmacy coverage under the state employee health plan for myself and my eligible dependents. At the same time that I become covered by the state employee health plan, the state will cease accruing my waiver payment 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 experience a qualifying 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.

OFFICE USE ONLY:

Accepted by: ______________________ Date: ______________________

Rev. October 2016