CITY OF PROVIDENCE

Jorge O. Elorza, Mayor

PLEASE COMPLETE THE FOLLOWING RETIREE ALTERNATE HEALTHCARE COVERAGE CERTIFICATION

Retiree Name: _____

Retiree Phone Number:_____

Retiree Address: _____

Retiree New Employer: _____

Retiree New Employer Address and Phone Number: _____

_____

I hereby certify that (check the statement that applies to you):

☐ 1. I, a retiree, do not work and/or do not have access to coverage through my new employer. *Please note that if you are currently unemployed, on Social Security, or Medicare; please check statement #1.

☐ 2. I, a retiree, do have access to and am currently enrolled in coverage through my new employer.

☐ 3. I, a retiree, do have access to coverage through my new employer but they only offer an H.S.A. plan. (Please note, you cannot enroll in an H.S.A. plan and be on the City of Providence as Secondary Coverage)

☐ 4. I, a retiree, have access to other coverage through my new employer, but am not currently enrolled in that coverage. Please provide the date when you are eligible to enroll: _____.

If you selected #2 above, please provide the following information to the Benefits Office:

Copy of Insurance Card
2 Paystubs Showing the Deduction
Effective Date of Coverage

I understand that if I have access to healthcare coverage through another employer, I must provide the City of Providence with written confirmation of my insurance information.

I also understand that I am entitled to reimbursement for any employee contribution that I am required to make as a result of enrolling in my employer sponsored health plan. I understand that I will be responsible for providing the City of Providence with proof of my contribution and that if I cease to be a member of this plan at anytime, it is my responsibility to notify the City of Providence that reimbursement to me should be stopped. I understand that if I continue to accept reimbursement for my plan when I am no longer enrolled in that plan, that acceptance of reimbursement would be considered a false claim and/or fraudulent statement and may be subject to criminal and/or civil penalties, recoupment of all benefits paid for by the City on behalf of me, and termination of benefits.

I also understand that should I obtain other employment from an employer who offers health care coverage in the future, that I must enroll in such coverage and must advise the City of such employment and coverage within no later than thirty (30) days of beginning such employment. Failure to provide this information will result in my termination from City coverage, and the City may seek reimbursement for any amounts paid on my behalf.

In signing the below, I understand that the submission of untruthful or false information to the City may be considered a false claim and/or fraudulent statement and may be subject to criminal and/or civil penalties, recoupment of all benefits paid for by the City, and/or disciplinary action, including loss of healthcare coverage and/or other benefits.

Please send all documentation ALONG with your contact information (please include the best phone number to reach you at along with an email address if applicable) to Susan Brophy or at the City of Providence, Benefits Department, Post Office Box 1656, Providence RI 02901 or email sbrophy@providenceri.gov (Contact phone: 401-680-5241).

Signature: _____

Date _____

HUMAN RESOURCES
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