CITY OF PROVIDENCE
Jorge O. Elorza, Mayor

COORDINATION OF BENEFITS CERTIFICATION FORM

Employee Name:_____
Employee Contact Information: _____
Employee's Department: _____
Spouse/Ex-Spouse Name: _____
Spouse/Ex-Spouse Address: _____
Spouse/Ex-Spouse Employer: _____
Spouse/Ex-Spouse Employer Address: _____

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

	1.	My Spouse (ex-spouse) is currently unemployed or retired
	2.	My Spouse (ex-spouse) is currently on Medicare. **You are exempt from obtaining individual coverage**
	3.	My Spouse (ex-spouse) is currently on Social Security or Disability. **You are exempt from obtaining individual coverage**
	4.	My Spouse (ex-spouse) is self-employed
	5.	My Spouse (ex-spouse) is currently working but does not have access to coverage through his/her employer
	6.	**My Spouse (ex-spouse) has access to coverage through his/her employer but they only offer an H.S.A. plan. You are exempt from obtaining individual coverage**
	7.	My Spouse (ex-spouse) is currently enrolled with VA coverage. **You are exempt from obtaining individual coverage**
	8.	My Spouse (ex-spouse) currently works for the City of Providence/Providence School Department
	9.	My Spouse (ex-spouse) currently has access to coverage and is enrolled through his/her employer
	10.	My Spouse (ex-spouse) has access to but is not currently enrolled in coverage through his/her employer. **Please provide the date when he/she will be able to enroll in coverage: _____**

If you selected #9 or #10 above, please attach the following:
- Photocopy of your spouse/ex-spouse's new primary ID card
- Proof of individual coverage
- Effective date of coverage
- 2 pay stubs showing your spouse's/ex-spouse's individual deduction

***A letter from your spouse's/ex-spouse's employer on company letterhead and containing all of the above information is also sufficient ***

By 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 suspension of healthcare coverage and potential termination of employment .

I also understand that if my spouse/ex-spouse has access to health care coverage through his/ her employer, I must provide the City of Providence with written confirmation of my spouse's/ex-spouse's insurance information (as outlined above) **within 30 days of the date of this letter.** Additionally, I understand that if my spouse/ex-spouse does not have access to other employer coverage at this time, but obtain access to health care coverage in the future, my spouse/ex-spouse must enroll in that coverage, and must provide the City with required documentation within 30 days of this coverage becoming available. Failure to provide this information will result in my spouse's/ex-spouse's suspension from City coverage, and the City may seek reimbursement for any amounts the City has paid on behalf of my spouse.

Additionally, by signing the below, I understand that I am entitled to a reimbursement for any employee contribution that my spouse/ex-spouse is required to make as a result of enrolling in individual coverage through their own employer sponsored health plan. I understand that the reimbursement will be paid to me, the employee, and not to my spouse/ex-spouse. I also understand that I will be responsible for providing the City of Providence with proof of my spouse's/ex-spouse's employee contribution, and that if he/ she loses health care coverage under his/ her employer's plan at any time, it is my responsibility to notify the City of Providence that reimbursement to me should be stopped. I understand that continuing to accept reimbursement for my spouse's/ex-spouse's plan after my spouse/ex-spouse is no longer enrolled in that plan, could be considered my submission of 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 suspension of healthcare coverage and potential termination of employment.

Signature: _____

Date: _____

Completed forms should be sent to:

City of Providence
Benefits Department – COB
Attn: Claire
25 Dorrance Street
Providence, RI 02903