City of Providence

Opt Out Form

Local Union 1339

Completed forms and proof of alternate coverage must be submitted to the Benefits Department via email to benefits@ppsd.org, fax to (401) 680-5457 or interoffice mail to Benefits Department – City Hall by September 30, 2020.

I, _____,
(EMPLOYEE NAME – please print)

Hereby certify that I have alternate health and/or dental coverage and request to receive a cash payment from the City of Providence in lieu of health and/or dental coverage for the period of **October 1, 2020 to September 30, 2021.**

I understand that should I lose my alternate coverage after declining City coverage, I will be re-enrolled in the City plan the first of the month following my notification to the City. **If I opt back into City benefits midyear, it must be as a result of loss of other coverage, and I will not receive partial year payment.**

I recognize that I will not be eligible for this cash payment unless my request is approved by the Benefits Office.

I understand that my alternate coverage must be equivalent coverage to that provided by the City and that my alternate coverage cannot be coverage provided by the City.

I hereby decline the following coverage and elect the cash payment, which shall be paid in **October 2021: (check Individual or Family)**

	Individual	**Family**
Healthcare	☐ $750	☐ $1,500
Dental	☐ $125	☐ $250

As evidence of alternative coverage, I hereby attach a copy of my alternative coverage card(s) for myself (Individual coverage), or for myself and another covered dependent (Family coverage).

SIGNATURE **DATE**

Office Use Only

Approved _____ Disapproved _____ Forwarded On _____