City of Providence
Local Union 1033
Opt Out Form

Completed and signed forms with proof of alternate coverage must be submitted to the Benefits Office via email to benefits@providenceri.gov by June 30, 2020.

I, _____,
(EMPLOYEE NAME – please print)

Hereby certify that I have alternate healthcare coverage and request to receive a cash payment from the City of Providence in lieu of medical coverage (which includes prescription coverage) for the period of **July 1, 2020 to June 30, 2021**.

Under the Collective Bargaining Agreement, I am not eligible to opt out of Dental coverage.

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 division of the Human Resources Department.

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 **July 2021: (check the box that applies)**

☐	Healthcare Individual Coverage	$ 750.00
☐	Healthcare Family Coverage	$1,500.00

As evidence of alternative coverage, I hereby attach a copy of my alternative coverage card or plan. If declining Family coverage, you must submit copies of at least two family members' alternate coverage cards.

SIGNATURE **DATE**

Office Use Only

Approved _____ Disapproved _____ Forwarded On _____