City of Providence

Retiree Healthcare Deferral Form

Retiree Information:

Name _____ **Date of Birth** _____

Address _____ **Social Security #** _____

_____ **Retirement Date** _____

Spouse/Partner Information:

Name _____ **Date of Birth** _____

Address _____ **Social Security #** _____

_____ **Retirement Date** _____

I defer medical coverage in accordance with Appendix C, Paragraph C-9.5 of The Providence Teachers Union Contract. I would like to defer my coverage as follows:

Please select the coverage(s) you wish to defer:

Retiree	☐ Medical	☐ Prescription	☐ Dental	☐ Vision
Spouse/Partner	☐ Medical	☐ Prescription	☐ Dental	☐ Vision

I understand that I cannot make changes to my healthcare coverage until:

- Open Enrollment (December 1 – December 31 for an effective date of January 1), or
- I experience a qualifying event, in which case I have 30 days to enroll in any of the above coverage(s).

_____ _____

Retiree Signature **Date**

If you have any questions or need additional information, please contact the Benefits Office by phone at 401-680-5285 or email to benefits@ppsd.org.

Benefits Office Use Only			
Plan Name	Deduction Stopped	Date	Initials