Providence School Department

Benefit Option Form

Teachers Hired Before 8/30/2004

Due to a change in your status, different rates for medical and dental plans apply and are listed below. Please indicate below which plan you are enrolling in. Rates are subject to change and you will be notified of such changes as soon as possible. Please return this form to the Benefits Office via email to benefits@ppsd.org or fax to 401-680-5457 along with the appropriate completed forms, within 30 days of this letter to be eligible for benefits.

Open Enrollment occurs each year from September 1-30 for an October 1st effective date. This is the only time a change can be made to your coverage outside of a qualifying event (ex. marriage, birth/adoption, loss of coverage). You have 30 days from the date of the qualifying event to make changes to your benefits outside of Open Enrollment.

Name _____ **Employee ID** _____

Address _____ **Date** _____

_____ **Effective Date** _____

Reason for Change:

- ☐ Probationary
- ☐ Open Enrollment
- ☐ Return from Leave
- ☐ LTS 68 Days
- ☐ LTS 1st/2nd Semester
- ☐ LTS 135 Days

Rates are based on 21 payments per year. Payment for health and dental coverage will be made through payroll deduction.

Select	Plan Name	Tier	Bi-Weekly Cost
☐	BCBSRI No Deductible Plan	☐ Individual	$70.57
		☐ Family*	$188.36
☐	BCBSRI $750 Deductible Plan	☐ Individual	$0.00
		☐ Family*	$0.00
☐	Delta Dental	☐ Individual	$0.00
		☐ Family*	$0.00
☐	I waive medical and/or dental coverage at this time. I understand I will not be able to enroll again until the next Open Enrollment occurs.		

*If adding spouse, please provide copy of marriage license; if adding children, please provide copy of birth certificate(s).

_____ _____

Employee Signature **Date**

If you have any questions or need additional information, please contact the Benefits Office by phone at 401-680-5281 or email to benefits@ppsd.org.