City of Providence

Retiree Coordination of Benefits (COB)

In order to receive reimbursement for your payroll deductions, you must provide the below documents to the Benefits Office via email to benefits@providenceri.gov, fax to 401-680-5457 or mail to City Hall Benefits Office, Room 410 (PO Box 1656 Providence, RI 02901) **within 30 days**. If you have any questions or need additional information, please contact the Benefits Office by phone at 401-680-5279 or email to benefits@providenceri.gov.

Retiree Information

Name _____ **Employee ID** _____

Address _____ **Prior Department** _____

_____ **Telephone** _____

New Employer Information

Employer _____ **Telephone** _____

Address _____

I hereby certify that (check the statement that applies to you):	
☐ I, a retiree, do not work and or do not have access to coverage.	
☐ I, a retiree, have access to coverage through my new employer, but they only offer an H.S.A. plan. * Please note you cannot enroll in an H.S.A. plan and be on the City of Providence as Secondary Coverage.	
☐ I, a retiree, do have access to and am currently enrolled in coverage through my new employer.	
☐ I, a retiree, do have access to coverage through my new employer, but am not currently enrolled in that coverage. The date I will be eligible to enroll is_____.	
If you are enrolled in coverage through your employer, please provide the following required documentation to the Benefits Office at City Hall.	• Copy of Insurance Card • Two Paystubs showing that deduction or a letter from your employer stating the cost of your individual coverage. • Effective Date of Coverage

I understand that if I have access to healthcare coverage through my new employer, I must provide the City of Providence with written confirmation of my insurance information.

I also understand that I am entitled to reimbursement for any employee contribution that I am required to make as a result of enrolling in my employer sponsored health plan. I understand that I will be responsible for providing the City of Providence with proof of my contribution and that if I cease to be a member of this health plan at any time, it is my responsibility to notify the City of Providence that reimbursement to me should be stopped. I understand that if I continue to accept reimbursement for my plan when I am no longer enrolled in that plan, that acceptance of reimbursement would 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 on behalf of me, and termination of benefits.

I also understand that should I obtain other employment from an employer who offers health care coverage in the future, that I must enroll in such coverage and must advise the City of such employment and coverage within no later than thirty (30) days of beginning such employment. Failure to provide this information will result in my termination from City coverage, and the City may seek reimbursement for any amount paid n my behalf.

In 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 loss of healthcare coverage and/or other benefits.

Please send all documentation ALONG with your contact information (please include the best phone number to reach you at along with an email address if applicable) to the City of Providence, Benefits Department, P.O. Box 1656, Providence, RI 02901.

_____ _____

Signature Date