



City of Providence Non-Union 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 1, 2021**.

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 **July 1, 2021 to June 30, 2022**.

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 2022: (check all that apply)**

- | | | |
|--------------------------|--------------------------------|------------|
| <input type="checkbox"/> | Healthcare Individual Coverage | \$ 750.00 |
| <input type="checkbox"/> | Healthcare Family Coverage | \$1,500.00 |
| <input type="checkbox"/> | Dental Individual Coverage | \$ 250.00 |
| <input type="checkbox"/> | Dental Family Coverage | \$ 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 _____