City of Providence

Coordination of Benefits (COB)

In order to receive reimbursement for your spouse's payroll deductions, you must provide the below documents to the Benefits Office via email to benefits@providenceri.gov, or Interoffice Mail to City Hall Benefits Office Room 410 **within 30 days**. If you have any questions or need additional information, please contact the Benefits Office by phone at 401-680-5616 or email to benefits@providenceri.gov.

Employee

Name _____ Employee ID _____

Address _____ Department _____

_____ Telephone _____

Spouse/ Ex-Spouse

Name _____ Telephone _____

Employer _____ Emp. Phone _____

Address _____

I hereby certify that (check the statement that applies to you):

EXEMPT from Obtaining Individual Coverage, because my Spouse (Ex-Spouse) is:	MUST Obtain Individual Coverage through their Employer, because my Spouse (Ex-Spouse):
☐ Currently unemployed or retired ☐ Currently enrolled in Medicare or VA coverage. ☐ Currently on Social Security or Disability. ☐ Is self-employed ☐ Currently working but does not have access to coverage through his/her employer ☐ Has access to coverage through his/her employer but they only offer an H.S.A. plan. ☐ Currently works for the City of Providence/Providence School Department	☐ Has access to coverage and is enrolled through his/her employer ☐ Has access to, but is not currently enrolled in coverage through his/her employer. **Required documentation:** ➢ A photocopy of your spouse/ex-spouse's insurance ID card ➢ Two pay stubs showing the per paycheck deduction ➢ Effective Date of Coverage: _____ ➢ You may also provide a letter from your spouse's employer on company letterhead with all of the information or the individual coverage cost of said employer.

By 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 suspension of healthcare coverage and potential termination of employment.

I also understand that if my spouse/ex-spouse has access to health care coverage through his/ her employer, I must provide the City of Providence with written confirmation of my spouse's/ex-spouse's insurance information (as outlined above) **within 30 days.** Additionally, I understand that if my spouse/ex-spouse does not have access to other employer coverage at this time, but obtain access to health care coverage in the future, my spouse/ex-spouse must enroll in that coverage, and must provide the City with required documentation within 30 days of this coverage becoming available. Failure to provide this information will result in my spouse's/ex-spouse's suspension from City coverage, and the City may seek reimbursement for any amounts the City has paid on behalf of my spouse.

Additionally, by signing the below, I understand that I am entitled to a reimbursement for any employee contribution that my spouse/ex-spouse is required to make as a result of enrolling in individual coverage through their own employer sponsored health plan. I understand that the reimbursement will be paid to me, the employee, and not to my spouse/ex-spouse. I also understand that I will be responsible for providing the City of Providence with proof of my spouse's/ex-spouse's employee contribution, and that if he/ she loses health care coverage under his/ her employer's plan at any time, it is my responsibility to notify the City of Providence that reimbursement to me should be stopped. I understand that continuing to accept reimbursement for my spouse's/ex-spouse's plan after my spouse/ex-spouse is no longer enrolled in that plan, could be considered my submission of 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 suspension of healthcare coverage and potential termination of employment.

_____ _____

Employee Signature **Date**