



# 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](mailto:benefits@providenceri.gov) by **May 31, 2026**.

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, 2026 to June 30, 2027**.

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 2027: (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 (Non-Union Only) | \$ 250.00  |
| <input type="checkbox"/> | Dental Family Coverage (Non-Union Only)     | \$ 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.

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**SIGNATURE** **DATE**

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**Office Use Only**

Approved \_\_\_\_\_ Disapproved \_\_\_\_\_ Forwarded On \_\_\_\_\_