# Benefits Enrollment Form

| QE Date | HR13 | BN/PR | Medical |
|---|---|---|---|
| | | | |
| **Rx** | **Dental** | **Vision** | **Union** |
| | | | |

Please complete this form to enroll in healthcare coverage with the City of Providence. If you wish to cover dependents, you are required to provide documentation to support your relationship (i.e. marriage certificate, birth certificate, divorce decree, court order, etc.). Completed forms should be returned to the City Benefits Office via email to benefits@providenceri.gov, or Interoffice mail to the Benefits Office at City Hall. If you have any questions, please contact the Benefits Office by calling 401-680-5616.

## Employee Information

| | | | | | | |
|---|---|---|---|---|---|---|
| **Employee Name** | | | | | **Employee ID** | |
| | | | | | **Social Security #** | |
| **Street Address** including Unit/Apt | | | | | **Date of Hire** (mm/dd/yyyy) | |
| **City, State ZIP** | | | | | **Date of Birth** (mm/dd/yyyy) | |
| **Email** | | | | | **Phone** | |
| **Company/Union** | ☐ 1033 | ☐ Police | ☐Fire | ☐Non-Union | ☐WSB - 1033 | ☐WSB – Non-Union |
| **Marital Status** | ☐Single | ☐Married | ☐Separated | ☐Divorced | ☐Common Law (1033) | ☐Domestic Partner (Fire) |

## Coverage Type

| Medical/Rx | Dental | Vision | No Coverage |
|---|---|---|---|
| ☐Individual ☐Family<br>Fire & Police Options:<br>Individual ☐ +Spouse ☐ +Children | ☐Individual ☐Family | ☐Individual ☐Family<br>☐ Individual +1 | ☐ I am deferring healthcare coverage and have provided documentation of my alternate health insurance |

## Dependent Information (if there are additional dependents or address is different than Employee, please note on back of form)

| | | | | | | | | | | HR Use Only |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | ☐ | ☐ | ☐ | ☐ |
| | | | | | | | ☐ | ☐ | ☐ | ☐ |
| | | | | | | | ☐ | ☐ | ☐ | ☐ |
| | | | | | | | ☐ | ☐ | ☐ | ☐ |

I certify that the above information is true and correct to the best of my knowledge. I understand that I may not make changes to my benefit elections outside of Open Enrollment, unless I have a qualifying life event (i.e. marriage, birth/adoption of a child, loss of other coverage, divorce, etc.).

**Signature** _____ **Date** _____