



# 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](mailto:benefits@providenceri.gov), fax to 401-680-5457 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 Option 2.

## 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	<input type="checkbox"/> 1033 <input type="checkbox"/> Police <input type="checkbox"/> Fire <input type="checkbox"/> Non-Union <input type="checkbox"/> WSB - 1033 <input type="checkbox"/> WSB – Non-Union		
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Common Law (1033) <input type="checkbox"/> Domestic Partner (Fire)		

## Coverage Type

Medical/Rx	Dental	Vision	No Coverage
<input type="checkbox"/> Individual <input type="checkbox"/> Family (Fire/Police Options Individual) <input type="checkbox"/> +Spouse <input type="checkbox"/> +Children	<input type="checkbox"/> Individual <input type="checkbox"/> Family	<input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Individual +1	<input type="checkbox"/> 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)

First Name	MI	Last Name	Sex M/F	SSN	Date of Birth (mm/dd/yyyy)	Relationship Spouse/Child/Other	Medical/ Rx	Dental	Vision	Verified? HR Use Only
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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