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	☐Individual ☐Family	☐Individual ☐Family ☐ 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)

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
							☐	☐	☐	☐
							☐	☐	☐	☐
							☐	☐	☐	☐
							☐	☐	☐	☐

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** _____

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**

Blue Cross Blue Shield of Rhode Island

CDH Administration
40 Commercial Way, East Providence, RI 02914
Email: customerservice@londonhealthusa.com
Phone: 401-435-4700
Fax: 401-435-3937

Flexible Spending Account (FSA) Enrollment Form

Employee Information:

Employer Name:		Effective Date:	
First Name:	Last Name:		
Street Address:	City:	State:	Zip:
Email Address:	Phone #:		
Date of Birth:	Social Security #:		

Dependent/s Information:

Dependent Name:	Relation:	Date of Birth:	Order Debit Card: ☐ Yes ☐ No
Dependent Name:	Relation:	Date of Birth:	Order Debit Card: ☐ Yes ☐ No
Dependent Name:	Relation:	Date of Birth:	Order Debit Card: ☐ Yes ☐ No
Dependent Name:	Relation:	Date of Birth:	Order Debit Card: ☐ Yes ☐ No

** Please list additional dependents on back side of this enrollment form*

Employee's Flexible Benefit Per Pay Deduction / Allocation:

Health Care Spending Account:

$3,200.00 Maximum Annual Contribution *(set by IRS)* Annual Contribution $ _____

Dependent Care Spending Account:

$5,000.00 Maximum Annual Contribution *(set by IRS)* Annual Contribution $ _____

Commuter Spending Account:

$315.00 For Parking Maximum Monthly Contribution *(set by IRS)* Monthly Contribution $ _____

$315.00 For Transit Maximum Monthly Contribution *(set by IRS)* Monthly Contribution $ _____

I Understand That:

(1) My employer will be deducting the allocations stated above from pay check for the purposes of funding my Flexible Spending Account plan(s).

(2) My accounts will not automatically renew. During each annual open enrollment period, I understand that I must complete a new enrollment form indicating my account contributions for each new plan year.

(3) I cannot change or revoke this agreement at any time during the plan year unless I have a change in family status, marriage, divorce, death of spouse or child, birth or adoption of child, termination or commencement of employment of a spouse, or such other qualifying events allowed by the Internal Revenue Code that will permit a change or revocation of an election.

(4) London Health Administrators may reduce, cancel, or otherwise modify this agreement in the event they believe it is advisable in order to satisfy certain provisions of the Internal Revenue Code.

(5)This agreement is subject to the terms of the Company's Flexible Spending Benefits Plan, as amended from time to time, which shall be governed under applicable laws, and revokes any prior agreement relating to such plan(s).

(6) By signing this form, I agree to the terms and procedures listed herein.

Employee Signature: _____ **Date:** _____

Plan Administrator: London Health Administrators

Prudential

The Prudential Insurance Company of America, 751 Broad Street, Newark, New Jersey 07102 1-877-232-3619

ENROLLMENT FORM -ADDTIONAL LIFE INSURANCE
City of Providence

Control # 54180

Employee General Information	Effective Date of Coverage (for office use only) / /		
Last Name First Name MI	Email Address	Phone Number	
Address City State Zip Code			
Your Annual Earnings $ _____	Social Security Number – –	Date of Birth (Month/Day/Year) / /	Date Employed (Month/Day/Year) / /
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed			

Basic Term Life and Accidental Death & Dismemberment (AD&D)

Your employer offers you Basic Term Life and AD&D Insurance coverage at no cost to you. You will automatically be enrolled in this plan.

Optional Term Life: 1X ☐ 2X ☐ 3X ☐ 4X ☐ 5X ☐ Salary; Minimum of $10,000 and Maximum of $500,000

☐ Coverage option chosen ☐ No coverage chosen

Employees and/or Dependents may be ineligible for group insurance coverage while on active duty in the armed forces.

Accelerated Death Benefit Option is a feature that is made available to group life insurance participants. It is not a health, nursing home, or long-term care insurance benefit and is not designed to eliminate the need for those types of insurance coverage. The death benefit is reduced by the amount of the accelerated death benefit paid. There is no administrative fee to accelerate benefits. Receipt of accelerated death benefits may affect eligibility for public assistance and may be taxable. The federal income tax treatment of payments made under this rider depends upon whether the insured is the recipient of the benefits and is considered terminally ill or chronically ill. You may wish to seek professional tax advice before exercising this option.

NOTICE TO CONSUMER: THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMAL ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.

Prudential

The Prudential Insurance Company of America, 751 Broad Street, Newark, New Jersey 07102 1-877-232-3619

ENROLLMENT FORM – City of Providence

Control # 54180

Employee General Information			
Last Name	First Name	MI	Last 4 digits of Social Security No. XXX-XX-_____

Acceptance or Waiver of Coverage

☐ I am enrolling for coverage and I authorize my employer to deduct from my earnings until further notice my contributions for insurance under a contract issued by The Prudential Insurance Company of America. I understand that if I desire to increase the amount of my insurance or add dependent coverage hereafter, I may be required to furnish evidence of insurability for myself and/or my dependents. To the best of my knowledge and belief, I declare the statement above is true and understand it is the basis for determining the contribution for coverage. I also understand that for coverage to become effective, I must be actively at work during the enrollment period and on the effective date of the plan. If I apply for an amount that requires evidence of insurability satisfactory to The Prudential Insurance Company of America, I must be actively at work on the date of approval for the amount requiring satisfactory evidence of insurability.

☐ I do not wish to enroll for any of the above optional coverages. I certify that I have been given the opportunity by my above named employer to enroll for coverage. I understand that if I desire to enroll hereafter, I may be required to furnish satisfactory evidence of insurability to The Prudential Insurance Company of America for myself and/or my dependents.

FLORIDA RESIDENTS – Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree.

NEW YORK RESIDENTS – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. This warning ONLY applies to accident and disability coverage.

I have read and understand the terms and requirements of the fraud warnings included as part of this form.

This policy/certificate provides limited benefits. Review your certificate carefully

Employee Signature_____ Date Signed (Month/Day/Year) _____

Prudential

The Prudential Insurance Company of America, 751 Broad Street, Newark, New Jersey 07102 1-877-232-3619

ENROLLMENT FORM – City of Providence

Control # 54180

Employee General Information			
Last Name	First Name	MI	Last 4 digits of Social Security No. XXX-XX-_____

Important Notices

For residents of all states except Alabama, Arkansas, the District of Columbia, Florida, Kentucky, Louisiana, Maine, Maryland, New Jersey, New York, North Carolina, Pennsylvania, Puerto Rico, Rhode Island, Utah, Vermont, Virginia and Washington; WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

ALABAMA RESIDENTS – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

ARKANSAS, DISTRICT OF COLUMBIA, LOUISIANA and RHODE ISLAND RESIDENTS – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

KENTUCKY RESIDENTS – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

MAINE AND WASHINGTON RESIDENTS – Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company commits a crime. Penalties include imprisonment, fines, and denial of insurance benefits.

MARYLAND RESIDENTS – Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW JERSEY RESIDENTS – Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NORTH CAROLINA RESIDENTS – Any person who, with the intent to injure, defraud, or deceive an insurer or insurance claimant, knowing that the statement contains false information concerning a fact or matter material to the claim may be guilty of a class H felony.

PENNSYLVANIA and UTAH RESIDENTS – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

PUERTO RICO RESIDENTS – Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

VERMONT RESIDENTS – Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

VIRGINIA RESIDENTS – Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

You must also complete a separate beneficiary designation form. If you have any questions, please see Human Resources for details.

Basic Term Life, Accidental Death & Dismemberment, Optional Term Life, Dependent Term Life, Long-Term Disability, Short-Term Disability Insurance coverages are issued and or administered by The Prudential Insurance Company of America, 751 Broad Street, Newark, NJ 07102. Life Claims: 1-800-524-0542 and Disability Support 1-800-842-1718. The Booklet-Certificate contains all details, including any policy exclusions, limitations, and restrictions, which may apply. If there is a discrepancy between this document and the Booklet-Certificate/Group Contract issued by Prudential, the terms of the Group Contract will govern. Contract provisions may vary by state. California COA #1179, NAIC#68241. Contract Series: 83500.

Prudential

IMPORTANT INFORMATION ABOUT BENEFICIARY DESIGNATIONS

Use this form to designate or make changes to the beneficiary(ies) of your Group Insurance death proceeds. The information on this form will replace any prior beneficiary designation. You may name anyone or any entity as your beneficiary and you may change your beneficiary at any time by completing a new Group Insurance Beneficiary Designation/Change form. Common designations include individuals, estates, corporation/organizations and trusts. **Payment will be made to the named beneficiary. If there is no named beneficiary, or the named beneficiary predeceased the insured, settlement will be made in accordance with the terms of your Group Contract.**

DEFINITIONS

You may find the following definitions helpful in completing this form:

Primary Beneficiary(ies) – the person(s) or entity you choose to receive your life insurance proceeds. Payment will be made in equal shares unless otherwise specified. In the event that a designated primary beneficiary predeceases the insured, the proceeds will be paid to the remaining primary beneficiaries in equal shares or all to the sole remaining primary beneficiary.

Contingent Beneficiary(ies) – the person(s) or entity you choose to receive your life insurance proceeds if the primary beneficiary(ies) die (or the entity dissolves) before you die. Payment will be made in equal shares unless otherwise specified. In the event that a designated contingent beneficiary predeceases the insured, the proceeds will be paid to the remaining contingent beneficiaries in equal shares or all to the sole remaining contingent beneficiary.

INSTRUCTIONS FOR DESIGNATING A PRIMARY OR CONTINGENT BENEFICIARY

1. EMPLOYEE INFORMATION

- All information in this section is required.
- Unless otherwise indicated in Section 1, the information supplied on the form will apply to ALL coverages offered under the employer's group plan.
- Unless otherwise indicated in Section 2, the information supplied on the form will apply to all the Group Life coverage(s) issued by The Prudential Insurance Company of America to the group contract holder.

2. BENEFICIARY DESIGNATION

- You may name more than one primary and more than one contingent beneficiary. This form allows you to name up to four primary and four contingent beneficiaries. If you need additional space, please attach a separate sheet of paper.
- Please indicate the percentage share designated to each primary beneficiary. **The total for all primary beneficiaries must equal 100%.** If no percentages are specified, the proceeds will be split evenly among those named. Payment will be made to the named beneficiary. If there is no named beneficiary, or the named beneficiary predeceased the insured, settlement will be made in accordance with the terms of your Group Contract. **If designating percentages for contingent beneficiaries, the percentage for all contingent beneficiaries must also equal 100%.**
- You can name an individual, corporation/organization, trust, or an estate as a beneficiary. The following examples may be helpful in designating beneficiaries:

Individual: "Mary A. Doe"
- Each name should be listed as first name, middle initial, last name ("Mary A. Doe," not "Mrs. M. Doe")
- Include the address, telephone number, social security number, relationship and Date of Birth for each individual listed.
- Indicate the percentage to be assigned to each individual.

Estate: "Estate of the Insured"
- Select "Other" as the Beneficiary Description and write "Estate" in the blank space provided.
- Indicate the percentage to be assigned to the Estate of the Insured.

Corporation/Organization: "ABC Charitable Organization"
- Select "Corporation/Organization" as the Beneficiary Description.
- Write the legal name of the corporation or organization in the space for the Beneficiary's First Name.
- Include the address, city and state, telephone number and tax ID number of operation for each organization or corporation listed.
- Indicate the percentage to be assigned to the corporation or organization.

Trust: "The John Doe Trust. A Trust with a trust agreement dated 1/1/99 whose Trustee is Jane Smith."
- Select "Trust" as the Beneficiary Description.
- Indicate the percentage to be assigned to the trust.
- Complete Section 3, Trust Designation.

3. TRUST DESIGNATION

- Complete this section if you have named a trust as a primary or contingent beneficiary in Section 2. Fill in the name and address for each trustee.
- Fill in the title and date of the Trust Agreement in the space provided.

4. AUTHORIZATION/SIGNATURE

- The employee must read, sign and date the authorization.
- Submit the completed form to your Benefits Administrator or Human Resources (as directed by your employer) and keep a copy for your records.

Prudential

Group Insurance Beneficiary Designation/Change

DATE: ____/____/____

1. EMPLOYEE INFORMATION (please print)

Last Name	First Name	MI	Employee ID# (if applicable)	Marital Status (check one) ☐ Married ☐ Widowed ☐ Single ☐ Divorced	Gender (check one) ☐ Male ☐ Female	Has this insurance been assigned? ☐ Yes ☐ No

Address	City	State	ZIP Code	Daytime Phone	Home Phone	Date of Birth	Date of Hire	Date of Retirement (if applicable)

Name of Employer/Group Policyholder	Group Policy No.	Unless otherwise indicated below, this Beneficiary Designation/Change form applies to ALL coverages offered under my employer's group plan. This form applies only to ☐ Basic Life ☐ Basic AD&D ☐ Optional Term Life ☐ Optional AD&D ☐ GUL ☐ GVUL coverage(s).
The City of Providence		

2. BENEFICIARY DESIGNATION: I hereby revoke any previous designations of primary beneficiary(ies) and contingent beneficiary(ies), if any, and in the event of my death, designate the following:

A. Primary Beneficiaries

Beneficiary Description (check one)	First Name	MI	Last Name	Address (include city, state, ZIP)	Relationship	Date of Birth	SSN/Tax ID Number	Phone	% Share
☐ Individual ☐ Other _____ ☐ Trust ☐ Corporation/Organization									
☐ Individual ☐ Other _____ ☐ Trust ☐ Corporation/Organization									
☐ Individual ☐ Other _____ ☐ Trust ☐ Corporation/Organization									
☐ Individual ☐ Other _____ ☐ Trust ☐ Corporation/Organization									
							TOTAL: (Must equal 100%)		

B. Contingent Beneficiaries

Beneficiary Description (check one)	First Name	MI	Last Name	Address (include city, state, ZIP)	Relationship	Date of Birth	SSN/Tax ID Number	Phone	% Share
☐ Individual ☐ Other _____ ☐ Trust ☐ Corporation/Organization									
☐ Individual ☐ Other _____ ☐ Trust ☐ Corporation/Organization									
☐ Individual ☐ Other _____ ☐ Trust ☐ Corporation/Organization									
☐ Individual ☐ Other _____ ☐ Trust ☐ Corporation/Organization									
							TOTAL: (Must equal 100%)		

3. TRUST DESIGNATION - COMPLETE IF A TRUST HAS BEEN NAMED AS A BENEFICIARY IN SECTION 2

Trustee's Name (First, MI, Last)	Address (include city, state, ZIP)

And successor(s) in trust, as Trustee(s) under _____ **dated** _____ **as amended and executed by me and said Trustee.**

Title of Agreement — Date of Agreement

Prudential

Group Insurance Beneficiary Designation/Change

4. **AUTHORIZATION/SIGNATURE** I authorize my plan administrator to record and consider the individuals/institutions that I have named on this form as beneficiaries for benefits under the applicable employee benefit plans. If designating a trust as a beneficiary, I understand Prudential assumes no obligation as to the validity or sufficiency of any executed Trust Agreement and does not pass on its legality. In making payment to any Trustee(s), Prudential has the right to assume that the Trustee(s) is acting in a fiduciary capacity until notice to the contrary is received by Prudential at its Group Life Claim office. I agree that if Prudential makes any payment(s) to the Trustee(s) before notice is received, Prudential will not make payment(s) again.

Employee's Signature X _____ Date Signed _____

The employee must sign and date this form. The signature date must be the date the employee actually signed the form.