STATE OF RHODE ISLAND
DEPARTMENT OF ADMINISTRATION
Office of Employee Benefits
One Capitol Hill – 3rd Floor Providence, RI 02908-5890
Phone: (401) 574-8530 | Fax: (401) 574-9281 | Email: DOA.OEB@doa.ri.gov
www.employeebenefits.ri.gov

2024 RETIREE HEALTH COVERAGE ELECTION FORM
JUDGES AND LEGISLATORS*

NOTE: A retired judge/legislator and their spouse may use this form to enroll in State retiree medical coverage only if they are NOT eligible for Medicare. Dental and/or vision coverage is available to retired judges/legislators and spouses/dependents regardless of Medicare eligibility.

- **For RETIREE coverage,** check here ☐ *Complete Sections 1 and 3.*
- **For SPOUSE's or DEPENDENT's coverage,** check here ☐ *Complete Sections 1, 2 and 3.*

Section 1. Retiree Information

Retiree's Name: First	Middle	Last	Retiree's SSN

Retiree's Address: Street or PO Box	City	State	Zip Code

Retiree's Phone Number	Retiree's Email Address	Retiree's Date of Birth	Retiree's Sex
( )			☐ Male ☐ Female

Section 2. Spouse's/Dependent's Information** *Complete only to elect coverage for your Spouse/Dependent.*

Name: First	Middle	Last	SSN

Phone Number	Email Address	Date of Birth	Sex
( )			☐ Male ☐ Female

Section 3. Plan Selections

Requested coverage effective date:
(when you want coverage to begin) (must be 1st of month) _____ (MM/DD/YY)

Select plan(s) for enrollment *(If coverage is for two people only, there would be two individual plans. If coverage is for three or more people, there would be one family plan.)*

☐ Anchor Plan *(Individual: $774.70/mo; Family: $2,171.86/mo)*
☐ Anchor Plus Plan *(Individual: $828.89/mo; Family: $2,323.77/mo)*
☐ Anchor Choice Plan *(Individual: $769.12/mo; Family: $2,156.19/mo)*

☐ Anchor Dental Plan *(Individual: $34.29/mo; Family: $88.80/mo)*
☐ Anchor Vision Plan *(Individual: $5.37/mo; Family: $14.83/mo)*

- If I have a pension check, I authorize the Employees' Retirement System of Rhode Island to deduct the required contribution for my health insurance, and my spouse's health insurance if applicable, from my pension check each month.
- If I do not receive a pension check, I will be invoiced for my premiums by the State's medical administrator.

Retiree's Signature: _____ **Date:** _____

Spouse's/Dependent's Signature: _____ **Date:** _____
(if applicable)

Submit this form via fax (401-574-9281) or email (DOA.OEB@doa.ri.gov).

* Former legislators that do not have an ERSRI legislator pension are eligible for this coverage only if they served at least two full terms.
** If adding more than one dependent, please submit their information as shown in Section 2 in a separate attachment. Please also provide supporting documentation as shown on www.employeebenefits.ri.gov/enrollment/supporting-documentation.php.