STATE OF RHODE ISLAND
DEPARTMENT OF ADMINISTRATION – Office of Employee Benefits
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2024 PRE-65 RETIREE HEALTH COVERAGE ELECTION FORM*

STATE EMPLOYEES, PUBLIC SCHOOL TEACHERS, and DISABLED RETIREES

Date of Retirement On or After 10/1/2008

If you want to select coverage for BOTH retiree and spouse/dependent, or retiree and family (spouse plus dependents),you must fill out a SEPARATE form for each person. 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.

- **For RETIREE coverage,** check here ◯ *Complete Sections 1, 3 and 4 (if applicable).*
- **For SPOUSE/DEPENDENT coverage,** check here ◯ *Complete Sections 1, 2 (advise of different address if applicable), 3 and 4 (if applicable).*

Section 1. Retiree Information

First Name	Last Name	Date of Birth	Social Security Number
Type of Retiree: State ◯ Teacher ◯ Disability ◯	Have you ever worked for a RI city/town or school system? Yes ◯ No ◯	Have you purchased ERSRI service credit? Yes ◯ No ◯	

Street or PO Box	City	State	Zip Code	Years of State Service

Phone Number	Email Address	Sex
		Male ◯ Female ◯

Section 2. Spouse's/Dependent's Information

First Name	Last Name	Date of Birth	Social Security Number

Phone Number	Email Address	Sex
		Male ◯ Female ◯

Section 3. Medical/Prescription Coverage Plan Selection

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

Select one:

For retirees and spouses/dependents not eligible for Medicare, including retirees and spouses/dependents under 65

- ☐ Retiree Anchor Plan *(Individual: $1,361.11/$272.22*/mo; Family: $3,787.03/$2,698.14*/mo)*
- ☐ Retiree Anchor Plus Plan *(Individual: $1,456.42/$291.28*/mo; Family: $4,052.22/$2,887.08*/mo)*
- ☐ Retiree Value Plan *(Individual: $828.89/$165.78*/mo; Family: $2,323.77/$1,660.66*/mo)*

For a retiree under 59 with an ERSRI disability pension

- ☐ Active Employee Anchor Plan *($774.70/mo)*
- ☐ Active Employee Anchor Plus Plan *($828.89/mo)*

** Rate w/ 80% subsidy*

Section 4. Last Day of Work *Complete ONLY if you are a State employee transitioning from active employment to retirement*

When will be your last day of work (including discharge of vacation time)?
_____ (MM/DD/YY)

- By signing this enrollment form, 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.
- I understand that if my pension check is not large enough to support the premium deductions for the coverage I have elected, I will be invoiced for my premiums by the State's medical administrator and I will responsible for remitting payment in response thereto.
- If I am a new retiree, I understand that my first health premium deduction will come out of my first or second regular pension check, and that the deduction will cover multiple months of health coverage. If the deduction would account for more than 50% of my pension check, I prefer:
  - ☐ That the deduction be completed as quickly as possible (even if that means exhausting my full pension check)
  - ☐ That the deduction be taken over time (not to exceed 3 months)

Retiree's Signature:

_____ **Date:** _____

Spouse's/Dependent's Signature:
(if applicable)

_____ **Date:** _____

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

*This form is not for use by retired judges, legislators or State Police