STATE OF RHODE ISLAND
DEPARTMENT OF ADMINISTRATION
Office of Employee Benefits
One Capitol Hill – 3rd Floor Providence, RI 02908-5890
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www.employeebenefits.ri.gov

2024 PRE-65 RETIREE HEALTH COVERAGE ELECTION FORM*

STATE EMPLOYEES, PUBLIC SCHOOL TEACHERS and DISABLED RETIREES**

Date of Retirement Before 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 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

Type of Retiree:	State ◯	Public School Teacher ◯	Disability** ◯	Years of Service

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

Name: First	Middle	Last	SSN

Phone Number	Email Address	Date of Birth	Sex ◯ Male ◯ Female

Section 3. Health Care 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 age 65**

◯ Retiree Anchor Plan *(Individual: $774.70/mo; Family: $2,171.86/mo)*

◯ Retiree Anchor Plus Plan *(Individual: $828.89/mo; Family: $2,323.77/mo)*

- 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.

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).

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

OEB Oct 2023

** If you are a disabled retiree with a date of retirement before 10/1/2008, please contact the Office of Employee Benefits for enrollment assistance.