*STATE OF RHODE ISLAND*
**DEPARTMENT OF ADMINISTRATION**
**Office of Employee Benefits**
**One Capitol Hill – 3rd Floor**
**Providence, RI 02908-5890**
**Phone: (401) 574-8530**
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# MEDICARE EXCHANGE ELIGIBILITY FORM

*Please return this form to the Office of Employee Benefits by email, fax or hand-delivery. It is suggested that you submit this form two months before you enroll in Medicare. Demographic information from this form is transmitted to the State's third-party Medicare exchange (Via Benefits) at the end of each month.*

## Section 1. Retiree Information

***Always complete this section. Fill in all information.***

| Retiree's Name: First | Middle Initial | Last | Retiree's SSN |
|---|---|---|---|
| | | | |

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

| Retiree's Phone Number (include area code) | Retiree's Date of Birth | Retiree's Sex |
|---|---|---|
| | | ◯ Male ◯ Female |

Type of Retiree: ☐ State ☐ Public School Teacher ☐ Disability ☐ Judge ☐ Legislator ☐ State Police

| Date of Retirement: | Years of State Service: |
|---|---|
| | |

Qualifying Event (i.e., retirement, loss of coverage, turning 65, etc.):

## Section 2. Spouse's Information

***Complete only if your Spouse is purchasing a plan through the State's Medicare exchange vendor.***

| Spouse's Name: First | Middle Initial | Last | Spouse's SSN |
|---|---|---|---|
| | | | |

| Spouse's Phone Number (include area code) | Spouse's Date of Birth | Spouse's Sex |
|---|---|---|
| | | ◯ Male ◯ Female |

Was Spouse employed by the State of Rhode Island? ◯ Yes ◯ No