



CITY OF PROVIDENCE

Jorge O. Elorza, Mayor

**EMPLOYEES WHO ARE MARRIED
AND EMPLOYEES IN A DOMESTIC PARTNERSHIP**

COMPLETE THIS FORM IF A PERSON YOU HAVE DESIGNATED AS YOUR
SPOUSE, EX-SPOUSE OR DOMESTIC PARTNER
IS CURRENTLY ENROLLED
IN YOUR CITY OF PROVIDENCE PLAN

(The term "spouse" includes any person you have designated as a person eligible for enrollment in the City's Plan based a spousal or domestic relationship (past or present)

Employee Name: _____

Employee Contact Information: _____

Employee's Department: _____

Spouse Name: _____

Spouse's Address: _____

Spouse's Employer: _____

Spouse's Employer Address: _____

I hereby certify that (check the statement that applies to you):

- (1) My spouse is currently unemployed; OR
 - (2) My spouse does not have access to coverage through his or her employer; OR
 - (3) My spouse has access to and is currently enrolled in coverage through his or her employer
 - (4) My spouse has access to but is not currently enrolled in coverage through his/her employer
- (Please note that your spouse will be required to enroll in their employer's healthcare plan upon your receipt of this document). Please provide the date when coverage will be effective:

_____.

If you selected #3 above, please complete the below information or attach photocopy of your spouse's new primary ID card to this document:

Spouse's Insurance carrier: _____

Address of Insurance carrier _____

Policy Holder _____

Other family members covered on spouse's plan, if applicable (Please include names and dates of birth) _____

Group Name _____

Spouse's Member ID _____

In 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 has access to health care coverage through his or her employer, I must provide the City of Providence with written confirmation of my spouse’s insurance information (as outlined above) within 30 days of the date of this letter. Additionally, I understand that if my spouse does not have access to other employer coverage at this time, but obtains access to health care coverage in the future, my 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 suspension from City coverage, and the City may seek reimbursement for any amounts the City has paid on behalf of my spouse.

Additionally, in signing the below, I understand that I am entitled to a reimbursement for any employee contribution that my 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. I also understand that I will be responsible for providing the City of Providence with proof of my spouse’s employee contribution, and that if he or she loses health care coverage under his or 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 plan after my 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.

Signature: _____

Witness: _____

Date: _____

Completed forms should be sent to:

City of Providence
Benefits Department PA
PO Box 1656
Providence, RI 02901

PLEASE NOTE: IT IS IMPERATIVE THAT YOU USE THE ZIP CODE “02901” LISTED ABOVE. FAILURE TO DO SO MAY RESULT IN THIS OFFICE **NOT** RECEIVING YOUR DOCUMENTATION.

HUMAN RESOURCES

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401 421 7740 ph | 401 273 9510 fax
www.providenceri.com