



CITY OF PROVIDENCE

Jorge O. Elorza, Mayor

DIVORCED EMPLOYEES

(COMPLETE THIS FORM IF YOU ARE DIVORCED AND YOUR EX-SPOUSE IS CURRENTLY ENROLLED IN YOUR CITY OF PROVIDENCE PLAN)

Employee Name: _____

Employee Contact Information: _____

Employee's Department: _____

Ex Spouse Name: _____

Ex Spouse's Address: _____

Ex Spouse's Employer: _____

Ex Spouse's Employer Address: _____

Date of Divorce: _____

A COPY OF YOUR DIVORCE DECREE MUST BE ATTACHED TO THIS DOCUMENT

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

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

If you selected either #3 above, please complete the below information or attach photocopy of your qualifying ex-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 _____

EMPLOYEE: In signing the below, I understand that if my ex- spouse has access to health care coverage through his or her employer, I must provide the City of Providence with written confirmation of my ex-spouse's insurance information (as outlined above) within 30 days of the date of this letter. Additionally, I understand that if my ex- spouse does not have access to other employer coverage at this time, but obtains access to health care coverage in the future, he or she must enroll in that coverage, and that I must provide the City with required documentation within 30 days of any such coverage becoming available. Failure to provide this information will result in my ex spouse's suspension from City coverage, and the City may seek reimbursement for any amounts paid on behalf of my ex-spouse.

I also understand that as the employee of the City of Providence, I am entitled to reimbursement for any employee contribution that my ex- spouse is required to make as a result of enrolling in his/her own employer sponsored health plan. I understand that the reimbursement will be made out to me, the employee, and not to my ex-spouse. Any obligation to provide this reimbursement to my ex-spouse is my responsibility. I also understand that I will be responsible for providing the City of Providence with proof of my ex- spouse's employee contribution, and that if I become aware that he or she ceases to be a member of that plan at any time; it is my responsibility to notify the City of Providence that reimbursement to me should be stopped. I understand that if I continue to accept reimbursement for my ex-spouse's plan, when I know or have reason to know that my ex-spouse is no longer enrolled in that plan, that acceptance of reimbursement could be considered a false claim and/or fraudulent statement and may be subject to criminal and/or civil penalties, recoupment from me of all benefits paid for by the City on behalf of my ex-spouse, and/or disciplinary action, including suspension of my own healthcare coverage and potential termination of employment.

EX-SPOUSE: In signing the below, I understand that as an enrolled in the City of Providence healthcare plan, the employee whose plan I am covered under is entitled to a reimbursement for any employee contribution that I am required to make as a result of enrolling in my own employer sponsored health plan. I understand that the reimbursements will be made issued to the employee, and not to me, and that any obligation to provide this reimbursement to me is the responsibility of my ex-spouse. I agree to hold harmless and indemnify the City of Providence from any failure of my ex-spouse to provide me with reimbursement of any funds paid to him or her by the City of Providence.

I also understand that I will be responsible for providing the City of Providence with proof of my employee contribution, and that if I cease to be a member of that plan at any time, it is my responsibility to notify the City of Providence that reimbursement should be stopped. I understand that if the City continues to make reimbursement for my employer sponsored plan costs once I am no longer enrolled in the plan, I may be considered to have submitted a false claim and/or fraudulent statement and may be subject to criminal and/or civil penalties, and recoupment of all benefits paid for by the City.

BOTH PARTIES: 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.

In signing the below, I also certify that neither of us (the employee nor the ex-spouse) is re-married to any other individual, including by common law, or has a domestic partner.

EMPLOYEE Signature: _____

Witness: _____ Date: _____

EX-SPOUSE Signature: _____

Witness: _____ Date: _____

Completed forms (and a copy of your divorce decree) should be sent to:

City of Providence
Benefits Department SB
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