



## CITY OF PROVIDENCE

Angel Taveras, Mayor

### PLEASE COMPLETE THE FOLLOWING RETIREE ALTERNATE HEALTHCARE COVERAGE

#### CERTIFICATION

Retiree Name: \_\_\_\_\_

Retiree Phone Number: \_\_\_\_\_

Retiree Address: \_\_\_\_\_

Retiree Employer: \_\_\_\_\_

Retiree Employer Address: \_\_\_\_\_

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

\_\_\_ (1) I, a retiree, am currently unemployed; OR

\_\_\_ (2) I, a retiree, do not have access to coverage through my employer; OR

\_\_\_ (3) I, a retiree, do have access to and am currently enrolled in coverage through my employer

\_\_\_ (4) I, a retiree, do have access to but am not currently enrolled in coverage through my employer. Please provide the date when coverage will be effective:

\_\_\_\_\_.

If you selected either #2 or #3 above, please complete the below information:

Retiree Insurance carrier: \_\_\_\_\_

Address of Insurance carrier \_\_\_\_\_

Policy Holder \_\_\_\_\_

Other family members covered on the plan, if applicable (Please include names and dates of birth)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Group Name \_\_\_\_\_

Member ID \_\_\_\_\_

I understand that if I have access to healthcare coverage through another employer, I must provide the City of Providence with written confirmation of my insurance information within 30 days of the date of this letter.

I also understand that I am entitled to reimbursement for any employee contribution that I am required to make as a result of enrolling in my employer sponsored health plan. I understand that I will be responsible for providing the City of Providence with proof of my contribution and that if I cease to be a member of this plan at anytime, 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 plan when I am no longer enrolled in that plan, that acceptance of reimbursement would 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 on behalf of me, and termination of benefits.

I also understand that should I obtain other employment from an employer who offers health care coverage in the future, that I must enroll in such coverage and must advise the City of such employment and coverage within no later than thirty (30) days of beginning such employment. Failure to provide this information will result in my termination from City coverage, and the City may seek reimbursement for any amounts paid on my behalf.

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 loss of healthcare coverage and/or other benefits.

Signature: \_\_\_\_\_

Witness: \_\_\_\_\_

Date \_\_\_\_\_

**Completed forms should be sent to:**

Amy Gordon  
Benefits Department  
PO Box 1656  
Providence, RI 02901

#### **HUMAN RESOURCES**

Providence City Hall | 25 Dorrance Street, Room 401, Providence, Rhode Island 02903  
401 421 7740 ph | 401 273 9510 fax  
[www.providenceri.com](http://www.providenceri.com)