State of Rhode Island & Providence Plantations
DEPARTMENT OF ADMINISTRATION
Office of Employee Benefits
One Capitol Hill
Providence, RI 02908-5864
Phone: (401) 222-3160 Fax: (401)222-6391

COBRA ENROLLMENT FORM

NOTE: TO BE COMPLETED ONLY BY STATE EMPLOYEES (AND/OR THEIR DEPENDENTS) WHO RETIRE WITH STATE RETIREMENT MEDICAL BENEFITS WHO ELECT COBRA IMMEDIATELY UPON RETIREMENT.

STATE RETIREE INFORMATION

NAME: FIRST	MIDDLE	LAST	SOCIAL SECURITY NUMBER

ADDRESS: STREET OR PO BOX	CITY	STATE	ZIP CODE

PHONE NUMBER (INCLUDE AREA CODE)	DATE OF BIRTH	SEX	DATE OF RETIREMENT
( )		☐ MALE ☐ FEMALE	

DEPENDENT INFORMATION – COMPLETE ONLY IF COVERING DEPENDENTS

DEPENDENT FIRST NAME, MIDDLE INITIAL, LAST NAME	RELATIONSHIP	DOB	SSN	SEX
				☐ MALE ☐ FEMALE
				☐ MALE ☐ FEMALE
				☐ MALE ☐ FEMALE

COVERAGE (PLAN PROVIDERS) INFORMATION

United Healthcare; Delta Dental; Vision Service Plan

MEMBERSHIP TYPE – CHECK ONE

☐ Individual under 65 ☐ Family plan

ELECTION AND PLAN

☐ I **do** wish to continue my/our COBRA benefits under the employees benefit health plan:

PLAN:
- ☐ Medical Plan (always includes prescription)
- ☐ Medical Plan with Vision
- ☐ Vision Only
- ☐ Medical Plan with Vision and Dental
- ☐ Medical Plan with Dental
- ☐ Dental Only
- ☐ Vision and Dental

SIGNATURES

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT EACH MONTH AND THAT MY COVERAGE WILL BE CANCELLED FOR NON-PAYMENT.

RETIREE'S SIGNATURE: _____ DATE: _____

SPOUSE'S SIGNATURE: _____ DATE: _____