



RETIREE HEALTH CARE ELECTION FORM
For Non-Medicare Eligible and Disabled Under Age 59
STATE EMPLOYEES and PUBLIC SCHOOL TEACHERS

Each person to be covered must complete a *separate form*. If you want to select coverage for BOTH retiree and spouse, you must fill out TWO SEPARATE forms.

- For **RETIREE coverage**, check here Complete Section 1-3
- For **SPOUSE's coverage**, check here Complete Section 1-3

Section 1. Retiree Information Always complete this section. Fill in all information.

Retiree's Name: First	Middle	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 <input type="checkbox"/> Male <input type="checkbox"/> Female	

Section 2. Spouse's Information Complete only to elect coverage for your Spouse.

Spouse's Name: First	Middle	Last	Spouse's SSN	
Spouse's Phone Number (include area code) ()		Spouse's Date of Birth	Spouse's Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	

Section 3. Health Care Plan Selection

Coverage to begin: <i>(Must be 1st of month)</i> _____ (MM/DD/YY)
Select one: For retirees not eligible for Medicare, including retirees under age 65. <input type="checkbox"/> Early Retiree Plan <input type="checkbox"/> Value Plan Retiree on Disability Pension under Age 59 <input type="checkbox"/> Active Employee Plan

By signing this enrollment form, I authorize the Employees' Retirement System of Rhode Island to deduct the required contribution for my health insurance, and my spouse's health insurance if applicable, from my pension check each month.

Retiree's Signature: _____ **Date:** _____

Applicant (Spouse) Signature: _____ **Date:** _____