State of Rhode Island
Waiver of Pre-Tax Health Co-Share Form

Please submit this form to:
State of Rhode Island
Department of Administration
Office of Accounts and Control
Payroll
One Capitol Hill, Providence, RI 02908

Name: _____

Social Security Number: _____

Payroll Account Number: _____

Street Address: _____

City, State, Zip: _____

☐ I elect to pay for my share of the following benefits on a post-tax basis. I hereby revoke my election to have my share of these benefits provided on a pre-tax basis. I understand that my share of the cost of such benefits as checked below will be paid on a post-tax basis:

- ☐ Medical Coverage
- ☐ Dental Coverage
- ☐ Vision Coverage

_____ _____
Employee Date

_____ _____
Authorized by Agency Date