STATE OF RHODE ISLAND & PROVIDENCE PLANTATIONS
Department of Administration
Office of Employee Benefits
One Capitol Hill – 3rd Floor
Providence, RI 02908
Phone: (401) 574-8530
Fax: (401) 574-9281

GROUP LEGAL CARE PAYROLL DEDUCTION AUTHORIZATION FORM

◯ **New Hire (Date of hire: _____)** ◯ **Open Enrollment**

◯ **Status Change (Qualifying event: _____ Date of qualifying event: _____)**

1. EMPLOYEE INFORMATION *If handwritten, please print clearly and legibly*

NAME: _____
First MI Last

SSN:

2. COVERAGE ELECTION

◯ Individual
($3.11 biweekly premium)

◯ Family
($4.78 biweekly premium)

◯ Cancel coverage

3. EMPLOYEE APPROVAL AND AUTHORIZATION:

I hereby authorize the State of Rhode Island to deduct the applicable premium from my wages.

Employee Signature: _____ Date: _____

TO BE COMPLETED BY AGENCY HR STAFF:

Union Code: _____ Payroll Account Number: _____