



**2020 PRE-65 RETIREE HEALTH COVERAGE ELECTION FORM\***  
**STATE EMPLOYEES, PUBLIC SCHOOL TEACHERS and DISABLED RETIREES\*\***  
***Date of Retirement Before 10/1/2008***

If you want to select coverage for BOTH retiree and spouse/dependent, or retiree and family (spouse plus dependents), you must fill out a SEPARATE form for each person. If coverage is for two people only, there would be two individual plans. If coverage is for three or more people, there would be one family plan.

- For RETIREE coverage, check here *Complete Sections 1 and 3.*
- For SPOUSE's or DEPENDENT's coverage, check here *Complete Sections 1, 2 and 3.*

**Section 1. Retiree Information**

Retiree's Name:			First	Middle	Last	Retiree's SSN
Type of Retiree:			State	Public School Teacher	Disability**	Years of Service
Retiree's Address:		Street or PO Box		City	State	Zip Code
Retiree's Phone Number	Retiree's Email Address		Retiree's Date of Birth		Retiree's Sex Male      Female	

**Section 2. Spouse's/Dependent's Information**

Name:			First	Middle	Last	SSN
Phone Number	Email Address		Date of Birth		Sex Male      Female	

**Section 3. Health Care Plan Selection**

<b>Requested coverage effective date:</b> <i>(when you want coverage to begin) (must be 1<sup>st</sup> of month)</i>		_____
		(MM/DD/YY)
Select one:	<b>For retirees and spouses/dependents not eligible for Medicare, including retirees and spouses/dependents under age 65</b>	
	<input type="checkbox"/> Retiree Anchor Plan <i>(Individual: \$598.75/mo; Family: \$1,678.59/mo)</i>	
	<input type="checkbox"/> Retiree Anchor Plus Plan <i>(Individual: \$640.63/mo; Family: \$1,796.00/mo)</i>	

- 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.
- I understand that if my pension check is not large enough to support the premium deductions for the coverage I have elected, I will be invoiced for my premiums by the State's medical administrator and I will be responsible for remitting payment in response thereto.

**Retiree's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Spouse's/Dependent's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(if applicable)

**Submit this form via fax (401-574-9281) or email (DOA.OEB@doa.ri.gov).**

\*This form is not for use by retired judges, legislators or State Police.

\*\* If you are a disabled retiree with a date of retirement before 10/1/2008, please contact the Office of Employee Benefits for enrollment assistance.