



2020 RETIREE HEALTH COVERAGE ELECTION FORM JUDGES AND LEGISLATORS*

NOTE: A retired judge/legislator and their spouse may use this form to enroll in State retiree medical coverage only if they are NOT eligible for Medicare. Dental and/or vision coverage is available to retired judges/legislators and spouses/dependents regardless of Medicare eligibility.

- 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
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** Complete only to elect coverage for your Spouse/Dependent.

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

Section 3. Plan Selections

Requested coverage effective date: (when you want coverage to begin) (must be 1 st of month) _____ (MM/DD/YY)
Select plan(s) for enrollment (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.) <ul style="list-style-type: none"> <input type="checkbox"/> Anchor Plan (Individual: \$598.75/mo; Family: \$1,678.59/mo) <input type="checkbox"/> Anchor Plus Plan (Individual: \$640.63/mo; Family: \$1,796.00/mo) <input type="checkbox"/> Anchor Choice Plan (Individual: \$594.43/mo; Family: \$1,666.48/mo) <input type="checkbox"/> Anchor Dental Plan (Individual: \$34.13/mo; Family: \$88.41/mo) <input type="checkbox"/> Anchor Vision Plan (Individual: \$5.03/mo; Family: \$13.89/mo)

- If I have a pension check, 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.
- If I do not receive a pension check, I will be invoiced for my premiums by the State's medical administrator.

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).

* Former legislators that do not have an ERSRI legislator pension are eligible for this coverage only if they served at least two full terms.

** If adding more than one dependent, please submit their information as shown in Section 2 in a separate attachment. Please also provide supporting documentation as shown on www.employeebenefits.ri.gov/enrollment/supporting-documentation.php.