LABORERS' PUBLIC EMPLOYEES LOCAL 1033 NEW UNION NEW AGE NEW ERA

RHODE ISLAND PUBLIC EMPLOYEES' HEALTH SERVICES FUND

PRESCRIPTION PLAN INFORMATION & ENROLLMENT FORM

410 South Main Street, Providence, RI 02903 Tel. 401/331-1033 Fax 401/421-0244

SSN: _____-_____-_____	Subscriber Name: (Last, First) _____
Birth date: _____/_____/_____	Mailing Address: Street/Apt/Flr _____
Effective Date of Action: _____/_____/_____	City:_____ State: _____ Zip: _____
Employer: Providence School B.E.S.T._____ BM_____ TA_____ CG_____ If LTS, please check _____	

ACTION CODE:

- ☐ - New Subscriber
- ☐ - Add Dependent to Family
- ☐ - Terminate Coverage
  Reason_____
- ☐ - Status Change
  - ☐ Individual to Family
  - ☐ Family to Individual
  - ☐ Retired
- ☐ - Remove Dependent
- ☐ - *Name/Address Change (*attach documentation)
- ☐ - Other (Please explain) _____
- ☐ - Buyout Option? If yes, please check.

DEPENDENT INFORMATION

Name (Last, First)	*Birth date(mm/dd/yyyy)*		*Gender*
Spouse			
Children *Documentation must be provided for student rider with this application and then each September and January thereafter		*Student Rider Max age through year that student attains age 25*	
		☐ Yes	
		☐ Yes	
		☐ Yes	
		☐ Yes	
		☐ Yes	
		☐ Yes	

Dated: _____

_____
Authorized Signature