STATE OF RHODE ISLAND
Department of Administration
Division of Human Resources, Office of Employee Benefits
One Capitol Hill – 3rd Floor. Providence, RI 02908
Phone: (401) 574-8530 | Fax: (401) 574-9281
Email: doa.oeb@doa.ri.gov | Web: www.employeebenefits.ri.gov

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: ______________________________