Data Requests of the
Division of Public Utilities and Carriers
Set 1

DIV 1-20. Please provide a copy of the Buck Report supporting the pro forma City Retirement expense shown on Schedule HJS-S6.

Answer: The pro forma amount of $2,788,304 shown for City Retirement Expense was an estimated amount that was used in a prior filing. It was slightly higher than the FY 2013 amount and was used while we were awaiting a more precise FY 2014 amount. We requested an update, and have received the attached letter from the City of Providence Finance Director, Michael Pearis, which states that the FY 2014 pro-forma amount should be $2,945,209. We will adjust this in rebuttal testimony.

Michael L. Pearis
Finance Director

Angel Taveras
Mayor

Finance Department
"Building Pride In Providence

Jeanne Bondarevskis
Senior Director - Administration
Providence Water
552 Academy Ave
Providence, RI 02908

Jeanne,

As you know, we are currently in litigation with Buck Consultants, therefore we do not have an updated actuarial report restating our ARC projections based on the impact the retiree settlement (which saves us over $14MM in ARC payments) and the payment of 90% of the FY12 ARC. We budgeted an overall, city-wide ARC of $62MM for FY14 based partly on the Funding Improvement Plan (FIP) prepared by Buck and submitted to the Department of Revenue in November 2012. In being conservative, we used $62MM instead of the published schedule (attached) of $60MM . The problem with using the FY14 ARC payment in the FIP of $60MM is that the FY14 number is not adjusted to reflect 90% payment of the FY12 ARC.

Buck provided us with a restated ARC for FY13 (attached) of $57.8MM, of which WSB was $2,745,769 or 4.75% of the total. We applied the 4.75% to the $62MM to come up with Providence Water's FY14 pension contribution of $2,945,209.

If you have any questions, please feel free to give me a call.

Sincerely,

Michael L. Pearis
Finance Director
City of Providence

SECTION V - APPROPRIATION PAYABLE BY CITY

1. Schedule A gives the basis for determining the appropriation payable by the City during the fiscal period beginning July 1, 2012. In accordance with the law governing the operation of the retirement system, the recommended contribution rates are 24.22% for Class A members, 81.79% for Class B Fire and 61.61% for Class B Police. These rates are based on amortizing the unfunded accrued liability as of June 30, 2011 on a level percentage-of-payroll basis over a 28-year period. If these rates are applied to the annual compensation of active members in this actuarial valuation, increased by $471,661 to amortize the remaining deferred contribution as of June 30, 1996 over a 30-year period, and adjusted to a monthly basis, contributions payable by the City for the fiscal year beginning July 1, 2012 are as shown below:

Group	Amount
Class A:	
General	$ 7,599,652
School	7,217,336
School Crossing Guards	854,982
Water	2,745,769
Workforce Development (JTPA)	342,620
Fire Civilians	220,721
Police Civilians	863,984
Total Class A	$ 19,845,064
Class B:	
Fire	$ 20,163,344
Police	17,793,151
Total Class B	$ 37,956,495
Grand Total	$ 57,801,559

FY13 City Pension

Group	Amount	%	FY14	FY15	FY16	FY17	FY18
Class A							
General	7,599,652.00	13.15%	$8,151,655.98	$8,196,672.97	$8,487,557.98	$8,788,867.64	$9,100,976.93
School	7,217,336.00	12.49%	$7,741,570.29	$7,784,322.61	$8,060,574.06	$8,346,725.72	$8,643,133.72
School Crossing Guards	854,982.00	1.48%	$917,083.98	$922,148.52	$954,873.89	$988,772.07	$1,023,885.23
Water	2,745,769.00	4.75%	$2,945,209.11	$2,961,473.83	$3,066,571.15	$3,175,434.92	$3,288,200.61
Workforce Development	342,620.00	0.59%	$367,506.35	$369,535.88	$382,650.04	$396,234.17	$410,305.20
Fire Civilians	220,721.00	0.38%	$236,753.16	$238,060.62	$246,508.96	$255,260.06	$264,324.83
Police Civilians	863,984.00	1.49%	$926,739.85	$931,857.71	$964,927.64	$999,182.73	$1,034,665.59
Total Class A	**19,845,064.00**	**34.33%**	**21,286,518.73**	**21,404,072.15**	**22,163,663.72**	**22,950,477.31**	**23,765,492.11**
Class B							
Fire	20,163,344.00	34.88%	$21,627,917.13	$21,747,355.91	$22,519,129.99	$23,318,562.69	$24,146,648.89
Police	17,793,151.00	30.78%	$19,085,564.15	$19,190,962.94	$19,872,015.29	$20,577,475.00	$21,308,220.00
Total Class B	**37,956,495.00**	**65.67%**	**40,713,481.27**	**40,938,318.85**	**42,391,145.28**	**43,896,037.69**	**45,454,868.89**
Grand Total	**57,801,559.00**	**100.00%**	**62,000,000.00**	**62,342,391.00**	**64,554,809.00**	**66,846,515.00**	**69,220,361.00**

New Citywide pension	$8,151,655.98	$8,196,672.97	$8,487,557.98	$8,788,867.64	$9,100,976.93
New Police pension	$20,012,303.99	$20,122,820.65	$20,836,942.93	$21,576,657.73	$22,342,885.59
New Fire Pension	$21,864,670.29	$21,985,416.52	$22,765,638.95	$23,573,822.75	$24,410,973.72
Total Pension	**$50,028,630.27**	**$50,304,910.15**	**$52,090,139.86**	**$53,939,348.12**	**$55,854,836.25**

School Pension **$8,658,654.28**

Exhibit B

Forecast of Actuarial Results - Funding Improvement Plan

Fiscal Year Ending	Payment Against the ARC	Employer Normal Cost	Past Service Amortization	Deferral Amortization	ARC	Contribution	Increase	Payroll	Contribution as a % of Payroll	Benefit Payments	Assets	Accrued Liability	Unfunded Liability	Funded Ratio	Revenue Forecast	Contribution as a % of Revenue
6/30/2012	90%	$ 8,654,179	$ 44,588,800	$ 492,606	$ 53,735,585	$ 48,362,027	-14.2%	$ 135,473,706	35.7%	$ 85,769,170	$ 413,804,423	$ 1,142,494,033	$ 728,689,610	36.2%	$ 434,806,177	11.1%
6/30/2013	100%	8,431,731	49,241,116	471,667	58,144,514	58,144,514	20.2%	135,473,706	42.9%	87,018,584	415,273,122	1,154,641,044	739,367,921	36.0%	437,830,844	13.3%
6/30/2014	100%	8,769,000	50,965,845	471,667	60,206,511	60,206,511	3.5%	140,215,285	42.9%	88,300,481	417,582,139	1,166,793,585	749,211,446	35.8%	432,611,543	13.9%
6/30/2015	100%	9,119,760	52,750,965	471,667	62,342,391	62,342,391	3.5%	145,122,820	43.0%	89,672,455	420,780,642	1,178,871,878	758,091,236	35.7%	432,771,186	14.4%
6/30/2016	100%	9,484,550	54,598,592	471,667	64,554,809	64,554,809	3.5%	150,202,119	43.0%	90,995,900	425,068,713	1,190,934,312	765,865,599	35.7%	432,826,535	14.9%
6/30/2017	100%	9,863,932	56,510,916	471,667	66,846,515	66,846,515	3.6%	155,459,193	43.0%	92,405,997	430,525,036	1,202,904,012	772,378,976	35.8%	437,154,800	15.3%
6/30/2018	100%	10,258,489	58,490,206	471,667	69,220,361	69,220,361	3.6%	160,900,265	43.0%	93,956,816	437,181,365	1,214,642,082	777,460,717	36.0%		
6/30/2019	100%	10,668,829	60,538,807	471,667	71,679,302	71,679,302	3.6%	166,531,774	43.0%	95,486,750	445,243,161	1,226,166,919	780,923,758	36.3%		
6/30/2020	100%	11,095,582	62,659,149	471,667	74,226,398	74,226,398	3.6%	172,360,386	43.1%	96,994,155	454,937,591	1,237,500,777	782,563,185	36.8%		
6/30/2021	100%	11,539,405	64,853,749	471,667	76,864,820	76,864,820	3.6%	178,393,000	43.1%	98,513,410	466,477,957	1,248,632,635	782,154,677	37.4%		
6/30/2022	100%	12,000,981	67,125,209	471,667	79,597,857	79,597,857	3.6%	184,636,755	43.1%	100,061,121	480,081,151	1,259,533,966	779,452,814	38.1%		
6/30/2023	100%	12,481,020	69,476,226	471,667	82,428,913	82,428,913	3.6%	191,099,041	43.1%	103,245,113	494,312,522	1,268,501,767	774,189,246	39.0%		
6/30/2024	100%	12,980,261	71,909,592	471,667	85,361,519	85,361,519	3.6%	197,787,508	43.2%	106,259,283	509,501,700	1,275,572,405	766,070,705	39.9%		
6/30/2025	100%	13,499,471	74,428,196	471,667	88,399,333	88,399,333	3.6%	204,710,070	43.2%	109,242,166	525,865,021	1,280,641,875	754,776,854	41.1%		
6/30/2026	100%	14,039,450	77,035,032	471,667	91,546,148	91,546,148	3.6%	211,874,923	43.2%	112,003,071	543,838,850	1,283,796,796	739,957,946	42.4%		
6/30/2027	100%	14,601,028	79,733,200	471,667	94,805,894	94,805,894	3.6%	219,290,545	43.2%	114,638,376	563,799,188	1,285,031,484	721,232,295	43.9%		
6/30/2028	100%	15,185,069	82,525,911	471,667	98,182,647	98,182,647	3.6%	226,965,714	43.3%	117,139,221	586,166,344	1,284,349,872	698,183,528	45.6%		
6/30/2029	100%	15,792,472	85,416,494	471,667	101,680,633	101,680,633	3.6%	234,909,514	43.3%	119,459,262	611,447,728	1,281,805,332	670,357,604	47.7%		
6/30/2030	100%	16,424,171	88,408,397	471,667	105,304,234	105,304,234	3.6%	243,131,347	43.3%	121,600,190	640,195,225	1,277,454,812	637,259,588	50.1%		
6/30/2031	100%	17,081,138	91,505,196	471,667	109,058,001	109,058,001	3.6%	251,640,944	43.3%	123,530,024	672,590,726	1,271,394,206	598,803,480	52.9%		
6/30/2032	100%	17,764,384	94,710,604	-	112,474,988	112,474,988	3.1%	260,448,378	43.2%	125,162,413	709,903,760	1,263,818,170	553,914,410	56.2%		
6/30/2033	100%	18,474,959	98,102,761	-	116,577,720	116,577,720	3.6%	269,564,071	43.2%	126,415,182	753,020,152	1,255,023,970	502,003,818	60.0%		
6/30/2034	100%	19,213,957	101,555,098	-	120,769,055	120,769,055	3.6%	278,998,813	43.3%	127,230,964	802,999,869	1,245,394,172	442,394,303	64.5%		
6/30/2035	100%	19,982,515	105,109,527	-	125,092,042	125,092,042	3.6%	288,763,772	43.3%	127,645,404	860,975,824	1,235,306,958	374,331,134	69.7%		
6/30/2036	100%	20,781,816	108,788,360	-	129,570,176	129,570,176	3.6%	298,870,504	43.4%	127,676,025	928,161,529	1,225,154,659	296,993,129	75.8%		
6/30/2037	100%	21,613,089	112,595,953	-	134,209,042	134,209,042	3.6%	309,330,971	43.4%	127,427,710	1,005,767,050	1,215,254,078	209,487,028	82.8%		
6/30/2038	100%	22,477,613	116,536,811	-	139,014,424	139,014,424	3.6%	320,157,555	43.4%	126,809,917	1,095,202,242	1,206,043,634	110,841,392	90.8%		
6/30/2039	100%	23,376,718	120,615,599	-	143,992,317	143,992,317	3.6%	331,363,070	43.5%	125,874,183	1,197,945,628	1,197,945,628	-	100.0%		
6/30/2040	100%	24,311,787	124,837,145	-	149,148,932	149,148,932	3.6%	342,960,777	43.5%	124,629,581	1,191,409,142	1,191,409,142	-	100.0%		
6/30/2041	100%	25,284,258	-	-	25,284,258	25,284,258	-83.0%	354,964,404	7.1%	123,003,600	1,186,997,185	1,186,997,185	-	100.0%		
6/30/2042	100%	26,295,628	-	-	26,295,628	26,295,628	4.0%	367,388,159	7.2%	121,049,601	1,158,980,501	1,158,980,501	-	100.0%		

Data Requests of the
Division of Public Utilities and Carriers
Set 1

DIV 1-21. Please state whether any change has been made in the state unemployment insurance compensation limit per employee that would result in an increase in the state unemployment insurance expense for rate year. If yes, please identify the change.

Response: No, because Providence Water is a direct reimbursement employer.

Data Requests of the
Division of Public Utilities and Carriers
Set 1

DIV 1-22. Please identify the cash payments made to employees who do not take healthcare coverage from Providence Water and state whether those payments are adjusted annually for inflation.

Answer: The cash payments made to employees who opt out of healthcare coverage are not adjusted for inflation. Total cash payments in FYE 6/30/12 were $9,500.

Data Requests of the
Division of Public Utilities and Carriers
Set 1

DIV 1-23. Please provide a copy of Providence Water's employee benefits handbook or similar document explaining the benefits to which employees are entitled.

Answer: Providence Water does not have an employee handbook. However, the following attached documents are provided from Providence Water and the City of Providence to a new employee.

a. PW New Hire Information -Non Union and Union.
b. City Of Providence Handouts –Non Union and Union.

Div 1-23 A

Non-Union
New Hire Information

Payroll - You will be paid every two weeks; however, and unfortunately, it does take several weeks to get onto the payroll...Direct Deposit is available

Vacation - 1 week after 6 months then 1 week on 1 Year anniversary date; 2 weeks every January 1st thereafter until 5th year of employment can be taken in ½ day increments

Sick Time - 1-¼ days per month or 15 per year...can be taken in ½ day increments

Personal Days - 2 days per contract year (7/1 to 6/30)...subtracted from sick time accrual... can be taken in ½ day increments

Floating Holidays – 3 per calendar year. Must use by 12/31 or lose...can be taken in hour increments

Holidays

- New Year's Day
- Martin Luther King Jr.'s Birthday
- President's Day
- Memorial Day
- Fourth of July
- Victory Day
- Labor Day
- Columbus Day
- Veteran's Day
- Election Day (November of each even year)
- Thanksgiving Day and Day after
- Christmas Day
- Christmas Eve (1/2 Day)
- New Year's Eve (1/2 Day)

Retirement- MANDATORY 8% of Gross Salary is deducted Pre-Tax.

Health Care Plan - Blue Cross-Health Mate – Plan 200 (there is a co-share)... includes prescription coverage, which is provided by CVS/Caremark...***Coverage is effective 1st of the month following your hire date***

Dental Plan – Delta Dental (100% paid by City)...***Coverage is effective 1st of the month following your hire date***

Life Insurance - $ 15,000 (paid by City)... Hartford Mutual Life

Optional Payroll Deductible Benefits

Flexible Spending Accounts (FSA's) - Pre-Tax dollars for medical and dependent care expenses (*PayFlex*)

Deferred Compensation (457) Plans - (Pre-Tax)

ING

Joseph Reynolds
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Warwick, RI 02886
401-738-2221

Great West- Brian Rocha, Account Executive.
255 Bear Hill Road, Waltham, MA 02451
Office Phone: 866-317-6584, Ext. 20087
Cell: 401-533-1848
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AIG - VALIC

Neil Lambert
1000 Winter Street, Suite 3750
South Waltham, MA. 02451
617-835-1207
neil_lambert@aigvalic.com

New Hire Information

Probation – Seniority shall be acquired after the completion of a six month probationary period, at which time seniority shall be retroactive to the first day of employment... see page 15 of the CBA for more information.

Payroll - You will be paid bi-weekly; however, and unfortunately, it does take several weeks to get onto the payroll...Direct Deposit is available.

Vacation - 1 week after 6 months...1 week on 1 Year anniversary date; 2 weeks every January 1st thereafter until 5th year of employment. Vacation time can be taken in a minimum of ½ day increments.

Sick Time - 1-¼ days per month or 15 per year...can be taken in a minimum of ½ day increment.

Personal Days - 2 days per contract year (7/1 to 6/30)...subtracted from sick time accrual... can be taken in a minimum of ½ day increment.

Floating Holidays – 3 per calendar year **Must** use all by 12/31 or lose...can be taken in a minimum of 1 hour increments

Holidays

- New Year's Day
- Martin Luther King Jr.'s Birthday
- President's Day
- Memorial Day
- Fourth of July
- Victory Day
- Labor Day
- Columbus Day
- Veteran's Day
- Election Day (November of each even year)
- Thanksgiving Day and Day after
- Christmas Day
- Christmas Eve (1/2 Day)
- New Year's Eve (1/2 Day)

Retirement- 8% of Gross Salary is deducted - Pre-tax.

Health Savings Account - Effective July 1, 2008, are required to contribute $.05/hour to the HAS for Retiree Post Medicare healthcare.

Health Care Plan- Blue Cross (see CBA for more information).

Dental Plan - Delta Dental (paid by City)

Prescriptions - MaxorPlus w/additional coverage via CVS/Caremark (Local 1033)

Vision - Davis Vision (Local 1033)

Coverages are effective 1st of the month following your hire date
(see Personnel for more information)

Longevity - Employees hired after 10/23/99, receive a longevity bonus of 3% of their annual salary after 7 years of service...this bonus is usually paid in a lump-sum at the end of each fiscal year (6/30)...after 12 years 4%...17 years...5%...20+ years 6%

Life Insurance - $25,000 policy provided by Local 1033

Accidental Death and Dismemberment- $25, 000 provided by Local 1033

Optional Payroll Deductible Benefits

Flexible Spending Accounts (FSA's) - Pre-Tax dollars for **dependent care** and/or **medical** expenses must sign up within **30 days of employment.**

Deferred Compensation (457) Plans - (Pre-Tax)

ING

Joseph Reynolds
100 Centerville Road, Suite 3
Warwick, RI 02886
401-738-2221

Great West- Brian Rocha, Account Executive.

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Office Phone: 866-317-6584, Ext. 20087
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Email: brian.rocha@gwrs.com

AIG - VALIC- Neil Lambert

1000 Winter Street, Suite 3750
South Waltham, MA. 02451
617-835-1207
neil_lambert@aigvalic.com

DIV 1-23 b. non-Union Handout

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

▶START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)*

Last Name (*Family Name*)	First Name (*Given Name*)	Middle Initial	Other Names Used (*if any*)

Address (*Street Number and Name*)	Apt. Number	City or Town	State	Zip Code

Date of Birth (*mm/dd/yyyy*)	U.S. Social Security Number	E-mail Address	Telephone Number
	___ - ___ - ___		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

☐ A citizen of the United States

☐ A noncitizen national of the United States (*See instructions*)

☐ A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "N/A" in this field. (*See instructions*)

For aliens authorized to work, provide your Alien Registration Number/USCIS Number OR Form I-94 Admission Number:

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

3-D Barcode
Do Not Write in This Space

Signature of Employee:	Date (*mm/dd/yyyy*):

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator:			Date (*mm/dd/yyyy*):
Last Name (*Family Name*)	First Name (*Given Name*)		
Address (*Street Number and Name*)	City or Town	State	Zip Code

Employer Completes Next Page

CITY OF PROVIDENCE

Angel Taveras, Mayor

DRUG FREE WORKPLACE POLICY ACKNOWLEDGEMENT
NEW HIRES

I, _____, an employee with the City of Providence hereby acknowledge That I have received a copy of the City's Policy regarding the maintenance of a Drug Free Policy Workplace. I have been informed that the unlawful manufacture, distribution, dispensation, possession or use of a controlled substance (to include but not limited to such drugs as marijuana, heroin, cocaine, PCP and crack, and may also include legal drugs which may be prescribed by a licensed physician if they are abused), is prohibited on the City's premises or while conducting city business. I also understand that convictions involving illicit drug behavior while off duty may result in disciplinary action. I acknowledge that I must report for work in fit condition to perform my duties. Violation of this policy make me subject to discipline up to and including termination. As a condition of City employment, I must abide by the terms of this policy and I will report to the employer any criminal drug conviction no later than five (5) days after such conviction. I realize that federal law mandates the employer to communicate this conviction to the appropriate federal agency under certain circumstances.

In accordance with the Drug Free Workplace Policy I certify that as a condition of my employment, I do not currently use illegal drugs.

_____ _____

Employee Date

COMMENTS IF ANY:

_____ _____

Department/Agency Signature Date policy reviewed with employee

5/94

HUMAN RESOURCES

Providence City Hall | 25 Dorrance Street, Room 401, Providence, Rhode Island 02903

401 421 7740 ph | 401 273 9510 fax

www.providenceri.com

CITY OF PROVIDENCE
Angel Taveras, Mayor

WORKERS' COMPENSATION INFORMATION IS REQUIRED ONLY AFTER A JOB OFFER HAS BEEN MADE

Are you or have you collected Workers' Compensation benefits for a job related injury?

Yes_____ or No_____ If yes, please give the date of your injury, nature of the injury, period of disability and present status of your injury.

_____

_____

_____

NOTICE

Please take note that under RI General Laws #28-35-57.1, Workers' Compensation claims shall be denied from the date an employee commences employment for a period of two (2) years if an employee has willfully provided false information or intentionally failed to disclose his or her workers' compensation history to the employer on an application requesting such information if the information relates to the injury, which is the basis of the new claim for compensation. Therefore, please take your time in completing and signing this questionnaire. If you need additional time to obtain the necessary information, you may request it.

CERTIFICATION

I hereby certify that the medical history information listed above is accurate to the best of my knowledge and belief.

_____ _____

Employee's signature Date

HUMAN RESOURCES
Providence City Hall | 25 Dorrance Street, Room 401, Providence, Rhode Island 02903
401 421 7740 ph | 401 273 9510 fax
www.providenceri.com

Form W-4 (2013)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2013 expires February 17, 2014. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,000 and includes more than $350 of unearned income (for example, interest and dividends).

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2013. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	A
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	B
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	D
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	E
F	Enter "1" if you have at least $1,900 of **child or dependent care expenses** for which you plan to claim a credit (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $65,000 ($95,000 if married), enter "2" for each eligible child; then **less** "1" if you have three to six eligible children or **less** "2" if you have seven or more eligible children. • If your total income will be between $65,000 and $84,000 ($95,000 and $119,000 if married), enter "1" for each eligible child	G
H	Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ►	H

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $40,000 ($10,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.

---------- Separate here and give Form W-4 to your employer. Keep the top part for your records. ----------

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

► Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.

OMB No. 1545-0074

2013

1 Your first name and middle initial	Last name	2 Your social security number
Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code	4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ► ☐	

5	Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)	5
6	Additional amount, if any, you want withheld from each paycheck	6 $
7	I claim exemption from withholding for 2013, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of all federal income tax withheld because I had **no** tax liability, and • This year I expect a refund of all federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ►	7

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature
(This form is not valid unless you sign it.) ► Date ►

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

CITY OF PROVIDENCE

Angel Taveras, Mayor

City of Providence Sexual Harassment Policy Acknowledgment
New Hires

I,_____, an employee with the City of Providence hereby acknowledge that I have received and read a copy of the City's Sexual Harassment Policy. Sexual Harassment is a form of discrimination and violates the following feeder, state and local laws:

- Title VII of the Civil Rights Act of 1964 as amended in 1972
- Rhode Island Fair Employment Practices Act, and the
- City of Providences Anti-Discrimination Ordinance

I have been informed that it is the policy of the City of Providence to prohibit sexual harassment of an employee by another employee or supervisor. In addition every employee is entitled to a working environment free from sexual harassment or offensive conduct of a sex-oriented or sex based nature regardless of its form or manner. Sexual harassment, both in general and as defined in this policy is unlawful conduct that will not be tolerated by the City of Providence. Offensive or inappropriate sexual behavior at work, including but not limited to, unwelcome sexual advances, request for sexual favors or other verbal or physical acts of a sexual or sex based nature where (a) submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment and/or (b) such conduct interferes with an individual's work performance or creates an intimidating, hostile of offensive working environment, is conduct which the City of Providence considers to be sexual harassment and is strictly prohibited. All employees must avoid any act or conduct which could be viewed by any other individual as sexual harassment. I also understand that if I'm a victim sexual harassment I can make a formal complaint to the City EEO/AA Officer at 421-7740 ext 250, or I can contact the Rhode Island Commission for Human Rights, 10 Abbott Park Place, Providence, Rhode Island 277-2661 or the Equal Employment Opportunity Commission, One Congress Street, Boston, Massachusetts, (617) 565-3200 either by phone, sending a written complaint or by going to either agency in person. I acknowledge that I as well as all my co-workers, supervisors, and colleagues are all entitled to a working environment free from sexual harassment or offensive conduct of a sex oriented or sex based nature. Violation of this policy make me subject to discipline up to and including termination. As a condition of City employment, I must abide by the terms of this policy and I will report to the employer any sexual harassment complaint I may have or see by my co-workers.

_____ _____

EMPLOYEE SIGNATURE DATE

_____ _____

DEPARTMENT/SIGNATURE DATE

HUMAN RESOURCES

Providence City Hall | 25 Dorrance Street, Room 401, Providence, Rhode Island 02903

401 421 7740 ph | 401 273 9510 fax

www.providenceri.com

Group Member Application for Health and Dental Insurance

Blue Cross Blue Shield of Rhode Island

Please be sure ALL information below is complete to avoid delays in processing.
Please print clearly using blue or black ink.

Section 1 Employee information (to be completed by plan administrator)

Group name		Effective date (mm/dd/yyyy)	Date of hire (mm/dd/yyyy)
Group number	Dept. number		

Choose one:
- ☐ Open enrollment
- ☐ New hire
- ☐ COBRA
- ☐ Loss of coverage (HIPAA Certificate of Creditable Coverage required)
- ☐ Other _____

or

Add dependent(s)
- ☐ Spouse
- ☐ Dependent

Date of event (mm/dd/yyyy) _____
(Must add within 31 days of marriage, birth, or adoption of dependent.)

Section 2 Employee information

Last name	Suffix	First name	M.I.

Home address (street/apartment number)	City/town	State	ZIP code

Mailing address (street/apartment number, city/town, state, ZIP code—if different from above)

Date of birth (mm/dd/yyyy)	Gender ☐ M ☐ F	Social Security number (xxx-xx-xxxx)*	What is your primary language spoken?

Home phone number	Cell phone number

Marital status (please check one)
☐ Single ☐ Married ☐ Divorced ☐ Common law ☐ Other _____

Primary care physician (PCP) name, street, city/town, state and ZIP code (mandatory for BlueCHiP plans)

Are you a current patient? ☐ Yes ☐ No	Provider ID

Section 3 Health Plan Options

Plan type

☐ Medical: ☐ Enrollee only ☐ Enrollee and spouse ☐ Enrollee and child(ren) ☐ Enrollee, spouse and child(ren)

☐ Dental: ☐ Enrollee only ☐ Enrollee and spouse ☐ Enrollee and child(ren) ☐ Enrollee, spouse and child(ren)

*Social Security number is required in order to comply with the reporting requirements of the Mandatory Insurance Reporting Law. See www.cms.hhs.gov/MandatoryInsRep/

What product(s) are you selecting?

- ☐ HealthMate Coast-to-Coast _____
- ☐ HealthMate Coast-to-Coast HDHP _____
- ☐ BlueSolutions for HRA _____
- ☐ BlueSolutions for HSA _____
- ☐ BlueCHiP _____
- ☐ Classic _____
- ☐ Dental _____

Section 4 – Spouse information

Last name	Suffix	First name	M.I.

Home address (street/apartment number, city/town, state, ZIP code—if different from employee)

Date of birth (mm/dd/yyyy)	Gender ☐ M ☐ F	Social Security number (xxx-xx-xxxx)*	What is your primary language spoken?

Home phone number	Cell phone number

Primary care physician (PCP) name, street, city/town, state and ZIP code (mandatory for BlueCHiP plans)

Are you a current patient? ☐ Yes ☐ No	Provider ID

Section 5 – Dependent information (If necessary, please attach dependent addendum.)

Dependent #1 First name	Last name	M.I.	Relationship ☐ Son ☐ Daughter

Date of birth (mm/dd/yyyy)	Social Security number (xxx-xx-xxxx)*

Primary care physician (PCP) name, street, city/town, state and ZIP code (mandatory for BlueCHiP plans)

Are you a current patient? ☐ Yes ☐ No	Provider ID

Dependent #2 First name	Last name	M.I.	Relationship ☐ Son ☐ Daughter

Date of birth (mm/dd/yyyy)	Social Security number (xxx-xx-xxxx)*

Primary care physician (PCP) name, street, city/town, state and ZIP code (mandatory for BlueCHiP plans)

Are you a current patient? ☐ Yes ☐ No	Provider ID

*Social Security number is required in order to comply with the reporting requirements of the Mandatory Insurance Reporting Law. See www.cms.hhs.gov/MandatoryInsRep/

Dependent #3 First name	Last name	M.I.	Relationship ☐ Son ☐ Daughter
Date of birth (mm/dd/yyyy)	Social Security number (xxx-xx-xxxx)*		
Primary care physician (PCP) name, street, city/town, state and ZIP code (mandatory for BlueCHiP plans)			
Are you a current patient? ☐ Yes ☐ No	Provider ID		

Dependent #4 First name	Last name	M.I.	Relationship ☐ Son ☐ Daughter
Date of birth (mm/dd/yyyy)	Social Security number (xxx-xx-xxxx)*		
Primary care physician (PCP) name, street, city/town, state and ZIP code (mandatory for BlueCHiP plans)			
Are you a current patient? ☐ Yes ☐ No	Provider ID		

☐ Check here if Group Dependent Addendum form will be attached.

Section C: Other Insurance

Are you or any of your dependents covered by other insurance? ☐ Yes ☐ No	Name of other insurance company and name(s) of covered person(s): Covered person 1 _____ Insurance company _____ Member ID #1 _____ Covered person 2 _____ Insurance company _____ Member ID #2 _____

What is the name of your prior health insurance carrier? _____ _____	What was the date of termination? (mm/dd/yyyy) _____ If loss of coverage, please attach a copy of the Certificate of Creditable Coverage.
Is anyone named in this application eligible for Medicare? ☐ Yes ☐ No	If yes, name of eligible person _____

Is the eligible person ☐ Over 65 ☐ Disabled	Retired date (if applicable) _____	Medicare number ___-___-____-____-____

Effective dates: (mm/dd/yyyy)
Part A (hospital): _____ Part B (medical): _____

*Social Security number is required in order to comply with the reporting requirements of the Mandatory Insurance Reporting Law. See www.cms.hhs.gov/MandatoryInsRep/

Section 7 Signature

By signing this form,

1.) I permit any physician, hospital, or other medical facility or provider to release medical records and reports to Blue Cross & Blue Shield of Rhode Island (BCBSRI) for me and my minor dependents. I permit BCBSRI to use such medical records and reports for purposes of:

- claims payment,
- case management,
- coordination of benefits,
- any other purpose directly related to the administration of BCBSRI, and
- inviting me and my enrolled members to take part in medical, disease, or case management programs.

This approval shall end two (2) years from the issue date of this plan, unless canceled sooner.

2.) I certify the information is true and complete to the best of my knowledge.

SIGN HERE ☞

Signature of applicant Date

Application rec'd date_____ ID #_____

Blue Cross Blue Shield of Rhode Island
www.BCBSRI.com

500 Exchange Street • Providence, RI 02903-2699

Delta Dental of Rhode Island
P.O. Box 1517
Providence, RI 02901-1517
800-84-DELTA

Please print

Employer Group Name	Delta Dental Group Number	Date of Hire	Location No. (if applicable)

Social Security No. / Subscriber I.D. No.	Subscriber Name: First - Last

Date of Birth - MM/DD/YYYY	Street Address / P.O. Box No.

Effective Date of Action	Apt. No.	City	State	Zip

QUALIFYING EVENT

- ____ Open Enrollment
- ____ New Hire/Re-hire
- ____ Marriage
- ____ Divorce
- ____ Birth or Adoption
- ____ Workers' Compensation
- ____ Return From Leave of Absence
- ____ Dependent's Loss of Coverage
- ____ Full-Time/Part-Time Status
- ____ Death of a Member

DEPENDENT INFORMATION

First Name Only If last name differs, please indicate in "other remarks" below.	Date of Birth	Relationship	Check box if full-time student over 19. Group must have student rider.
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐

ACTION CODE (Check One) *(Changes must be made on the first of the month)*
Explain in "Other Remarks" if necessary.

ADDITIONS:
- ____ New Subscriber
- ____ Add Dependent to Existing Family Coverage
- ____ Reinstatement

TERMINATION:
- ____ Remove Subscriber
- ____ Remove Dependent/Student (List dependent name.)

STATUS CHANGE:
- ____ Individual to Family
- ____ Family to Individual
- ____ Name / Address Change
- ____ Transfer from Sublocation #_____ to #_____

COBRA:
- ____ Reinstatement of Subscriber
- ____ Add Dependent: - (From Prior Subscriber ID #_____)

☐ Corrections / Other Remarks (Please Explain)

Type of Coverage: (Check One) ☐ Individual ☐ Family

COORDINATION OF BENEFITS

DENTAL — Are You or Any of Your Dependents Covered by Another Dental Plan? ☐ No ☐ Yes If Yes, Please Complete the Section Below.

Other Dental Insurance Name:_____ Type of Coverage: ☐ Individual ☐ Family

Other Dental Insurance Address:_____

Employer Name Through Which You/Your Dependents Have Other Insurance:_____

Group Policy No.	Policyholder Name	Policyholder ID No.

MEDICAL — Are You or Any of Your Dependents Covered by A Medical Plan? ☐ No ☐ Yes If Yes, Please Complete the Section Below.

Name of Medical Insurance Company/HMO:_____ Type of Coverage: ☐ Individual ☐ Family

Name of Health Plan/Type of Coverage:_____

Employer Name Through Which You/Your Dependents Have Other Insurance:_____

Group Policy No.	Policyholder Name	Policyholder ID No.

I certify that all information is true and correct to the best of my knowledge. Also, I understand that the effective date and termination date of my membership will be determined by my employer or plan sponsor in accordance with the underwriting guidelines of Delta Dental. In addition, if my employer requires employee contributions for this coverage, I authorize the deductions of these amounts from my wages periodically.

Employee Signature _____ Date _____ Benefits Administrator Authorization _____ Date _____

CITY OF PROVIDENCE

Angel Taveras, Mayor

EQUAL EMPLOYMENT OPPORTUNITY SURVEY

The City of Providence is required by Equal Employment Opportunity Commission (EEOC) and the Department of Housing and Urban Development (HUD) regulations to collect and maintain certain information in support of our Equal Employment Opportunity Program.

THE INFORMATION REQUESTED ON THIS SURVEY IS STRICTLY FOR EEO RECORD KEEPING PURPOSES ONLY.

NAME:_____
(LAST) (FIRST) (MIDDLE)

ADDRESS:_____

_____
CITY STATE ZIP CODE

SS# :_____ TELEPHONE#_____

D.O.B.:_____

GENDER: MALE:_____ FEMALE:___

RACE:

WHITE:_____

BLACK:_____

HISPANIC:_____

ASIAN & PACIFIC ISLANDER:_____

AMERICAN INDIAN/ALASKAN NATIVE:_____

HUMAN RESOURCES
Providence City Hall | 25 Dorrance Street, Room 401, Providence, Rhode Island 02903
401 421 7740 ph | 401 273 9510 fax
www.providenceri.com

CITY OF PROVIDENCE

Angel Taveras, Mayor

Emergency Contact Information Form

Your Name:_____
Last First Middle

Address:_____
Street City State ZIP

Cell phone:_____ Home phone:_____

Work Phone:_____ E-mail:_____

Person to contact in case of an Emergency:_____
Last First

Cell Phone:_____ Home Phone:_____

Work Phone:_____

If unavailable 2nd Contact Name:_____
Last First

Cell Phone:_____ Home Phone:_____

Work Phone:_____

Comments: *(include any special medical or personal information you would want an emergency care provider to know – or special contact information)*

_____

_____

_____

HUMAN RESOURCES

Providence City Hall | 25 Dorrance Street, Room 401, Providence, Rhode Island 02903

401 421 7740 ph | 401 273 9510 fax

www.providenceri.com

BENEFICIARY DESIGNATION

THE HARTFORD

☐ Initial Beneficiary Designation(s) OR ☐ Change of all prior beneficiary designation(s) *(check only one box)*, I hereby revoke any previous beneficiary designation(s), if any, for my group term life insurance and/or accidental death and dismemberment (AD&D) insurance issued to this group or employer and direct that the insurance proceeds payable under the policy be paid as indicated below.

Employee Name	Social Security Number ☐☐☐ ☐☐ ☐☐☐☐
Employee Address Street City State Zip Code	Telephone Number ( )
Policyholder/Employer	Policy/Employer Number

NAMING YOUR GROUP LIFE BENEFICIARY

It is important that your beneficiary designation be clear so that there will be no question as to your intent. It is also important that you name a primary and contingent beneficiary. When naming your beneficiary(ies) please indicate their full name, address, social security number, and relationship. If the beneficiary is not related either by blood or marriage, insert the words, "Not Related." If more than one primary or contingent beneficiary is named without a percentage indicated, the proceeds will be divided equally. On the reverse side of this form you will find examples of common beneficiary designations. If you need assistance, contact your Company representative or your own legal counsel.

Benefits payable for a Dependent's death are payable to You if living, otherwise, We may, at Our option, pay the benefit to Your surviving spouse or to the executors or administrators of Your estate.

PRIMARY BENEFICIARY(IES)

Name: _____ Date of Birth _____

Address: _____
Street City State Zip Code

Social Security Number: _____ Relationship: _____ Benefit Percent: _____

Name: _____ Date of Birth _____

Address: _____
Street City State Zip Code

Social Security Number: _____ Relationship: _____ Benefit Percent: _____

CONTINGENT BENEFICIARY(IES)

Name _____ Date of Birth _____

Address: _____
Street City State Zip Code

Social Security Number: _____ Relationship: _____ Benefit Percent: _____

Name: _____ Date of Birth _____

Address: _____
Street City State Zip Code

Social Security Number: _____ Relationship: _____ Benefit Percent: _____

Spousal Consent For Community Property States Only: If you live in a community property state - Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin - you may complete the Spousal Consent section, which allows your spouse to waive his or her rights to any community property interest in the benefit. Disclaimer: spousal consent does not apply to ERISA plans.

This will certify that, as spouse of the Employee named above, I hereby consent to my spouse designating the person(s) listed above as beneficiaries) of group life insurance under the above policy and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersede any prior spousal consent or waiver under this plan.

Signature of Employee's Spouse _____ Date _____

I, the undersigned, reserve the right to change the beneficiary(ies) without the consent of said beneficiary(ies).

Signature of Employee _____ Date _____

CITY OF PROVIDENCE

Angel Taveras, Mayor

ePay Enrollment

I, _____,

Employee ID or SSN_____ elect to enroll in the City of Providence ePay program, to receive future pay advices emailed to me at the following email address: _____

_____	_____	_____
Signature	Date	Telephone

The City of Providence is pleased to announce ePay, a new electronic paystub delivery program. Rather than printing, sorting and delivering thousands of paystubs, the City can now email your paystub directly to your personal email address or your City email. This process ensures early delivery of your pay information, while reducing paper, printing and mailing costs. Direct deposit of your funds will still occur on the same day as always, and the email will include an exact replica of the paper paystub you receive now. Tax withholding forms will still be mailed on an annual basis.

Employees are encouraged to register a personal email address for the ePay program.

HUMAN RESOURCES

Providence City Hall | 25 Dorrance Street, Room 401, Providence, Rhode Island 02903

401 421 7740 ph | 401 273 9510 fax

www.providenceri.com

DIRECT DEPOSIT AUTHORIZATION

COMPANY NAME: City of Providence

EMPLOYEE NAME: _____

EMPLOYEE ADDRESS: _____

ADDRESS: _____

CITY: _____

SOCIAL SECURITY #: _____

BANK NAME: _____

I HEREBY AUTHORIZE AND REQUEST YOU TO:

Deduct _____ from my net pay each pay period and deposit it to my

Statement Savings Account #_____

Deduct _____ from my net pay each pay period and deposit it to my

Club Statement Account # _____

Deduct _____ from my net pay each pay period and deposit it to my

Checking Account # _____

THIS AUTHORIZATION MAY BE CANCELED AT ANY TIME BY NOTIFICATION TO THE COMPANY. ANY SUCH NOTIFICATION SHALL BE EFFECTIVE ONLY AFTER THE COMPANY HAS HAD REASONABLE TIME TO ACT UPON IT.

SIGNATURE OF EMPLOYEE: _____

DATE: _____

PLEASE ATTACH A COPY OF AN ENCODED DEPOSIT SLIP OR ONE OF YOUR CHECKING ACCOUNT CHECKS FOR EACH ACCOUNT YOU HAVE LISTED ABOVE.

The City of Providence
Providence City Hall
25 Dorrance Street
Providence, Rhode Island 02903

Main telephone number (401) 421-7740
TDD 401 751-0203

www.providenceri.com

Regular Business Hours 8:30 AM to 4:30 PM
Summer hours (July & August) 8:30 AM to 4:00 PM

Orientation sheet Union employees

Vacation

An employee accrues 5 days vacation after 6 months.
An employee receives an additional week of vacation on their 1st year anniversary.
After one year of service, employee receives vacation accrual every January.

After 5 years of service, employee accrues an additional 5 days on the anniversary date. (3 weeks total)
After 10 years of service, employee accrues an additional 5 days on the anniversary date. (4 weeks total)
After 15 years of service, employee accrues an additional 5 days on the anniversary date. (5 weeks total)

Sick Leave

An employee accrues 1 ¼ days (8.75 hrs) every month for a total of 15 days annually. Your hire date must be on the 15th of the month or before in order to accrue the 8.75 hours for that month. Unused sick time may be carried over up to 135 days.

Personal days

You are allowed to convert two (2) personal days from your balance of sick day per year.

Floating Holiday

Employees may take three (3) floating holidays per calendar years.

Life Insurance

The Rhode Island Public Employees' Health Service Fund has the group life/AD&D policy with Assurant Insurance Company in the amount of $25,000.

Longevity

Employees hired after October 23, 1999, 7 years of employment, receive a longevity bonus of 4% of their annual salary. This bonus is usually paid in a lump sum at the end of the fiscal year. June 30th.

Longevity formula for employees is as follows:

Years of Service		Annual Percentage Amount
7	but less than 12 yrs	4%
12	but less than 17 yrs	5%
17	but less than 20 yrs	6%
20	or more	7%

Deferred Compensation

The City provides pre-taxed investment opportunities through payroll deduction. The following are participating providers:

NATIONWIDE RETIREMENT SOLUTIONS
William Redihan, retirement Specialist
PO Box 321
Orleans, MA 02653
Business Phone (877)677-3678 Extension 69003
Email: redihaw@nationwide.com

GREAT WEST RETIREMENT SERVICES
Brian Rocha
401-533-1848
(800)-701-8255

ING
Frank Leonard, Local Account Representative
Registered Representative
30 Braintree Hill Office Park
Braintree, MA 02184
Tel.:781-796-9859
Cell:Tel:RI 401-447-4431
Cell: 617-921-7652
Fax:781-796-9392
Frank@heritageretire.com

ICMA CORPORATION
Mike Savage
msavage@icmarc.org

AIG VALIC FINACIAL ADVISORS
1000 Winter Street
Suite 3750 South
Waltham, MA 02451
Glen Archambault (401) 952-5371
glen-archambault@aigvalic.com
Lynn Redding (401)-486-9638 (cell)
Lynn: redding@aigvalic.com

THE HARTFORD
Laura Slaven
Account Representative
(617) 378-4618

GROUP SAVINGS PLUS (HOME & AUTO INSURANCE)

LIBERTY MUTUAL INSURANCE COMPANY

Liberty Mutual makes it possible for City of Providence employees to enjoy discounted benefits on auto, home and tenant insurance, payment through payroll deductions, guaranteed 12-month policy rate, prompt claims insurance and 24-hour emergency roadside assistance.

Broker: Steven Moran, Roy Jann
Bottom Line solutions
1445 Wampanoag Trail, Ste 105
East Providence, RI 02915-1203
Business Phone (401) 433-1445
Moranis@aol.com
Call for free coverage and no-obligation quote : 1800-225-8281 or visit www.libertymutual.com

Payroll

You will receive your paycheck Bi- weekly. Your paycheck is delivered to you by your department Payroll Administrator on Thursday afternoon.
If you choose the direct deposit option, it will take approx three weeks for the initial request to be processed. The money will appear in the account of your choice (checking/savings) on Friday mornings after 7:00 A.M. You may choose up to 3 banking institutions to divert your paycheck providing the deposit equals 100% of your weekly net payroll amount.

Medical Coverage

You will begin coverage of benefits the 1st day of the month following your date of hire.

Medical Provider: Blue Cross Blue Shield of RI Blue Chip and Delta Dental Provider: Delta Dental of RI.
Website Blue Cross: www.bcbsri.com
Website Delta Dental: www.deltadentalri.com

Pension

The City of Providence deducts an 8% pension contribution.

Leave of Absence/Maternity Leave

Upon written application, an employee with permanent status may be granted a leave without pay not to exceed one year for reason of personal illness, disability, maternity leave, or other reason deemed appropriate and approved by the Human Resource Director.
Please contact Francis Gutierrez in the Human Resource Dept. ext 244.

ING-FINANCIAL

*Effective July 1, 2008 new employees shall **no longer** receive Retiree Post Medicare health benefits paid for by the employer, but the employer shall allow said employees to purchase Post Medicare eligible healthcare at the retirees cost and at the employers group rate. **Said employees shall be require to participate in a Health Savings Account (HAS) at a rate of $.05 per hour with the fund being used for said Retiree Post Medicare healthcare.**

***NEW HIRES SHALL BE COMPENSATED AT A WAGE RATE OF FIFTEEN PERCENT (15%) BELOW THE CONTRACTUAL RATE FOR THE PERIOD OF JULY 1, 2011 TO JULY 1, 2014. WAGES FOR NEW EMPLOYEES SHALL BE INCREASED IN FIVE PERCENT (5%) INCREMENTS ANNUALLY UNTIL JULY 1, 2014 AND ON THIS DATE THE NEW EMPLOYEES SHALL RECEIVE THE FULL CONTRACTUAL RATE.**

General Contact Information

Topic	Contact	Phone/e-mail address
Labor Relations/Employee Relations	Sybil Bailey Director of Human Resources 4th floor Room 401	401-421-7740 ext 617 Assistant Jennifer Conrad Jconrad@providenceri.com
Labor Relations/Employee Relations, Worker's Compensation	Steven Rotondo Deputy Director, HR 4th Floor, Room 401	401-421-7740 ext 616 mwingate@providenceri.com
Training Coordinator	Michael Welden Human Resources 4th floor Room 411	401-421-7740 ext 397 mwelden@providenceri.com
Entrance paperwork, sick, vacation longevity	Diane DiGiuseppe Human Resource Technician II 4th Floor, Room 411	401-421-7740 ext 239 **Fax#273-9510** ddigiuseppe@providenceri.com
Postings	Ebony Palmer Room 411 Human Resource Technician I	401-421-7740 ext 240 epalmer@providenceri.com
General payroll issues	Lori Lazzarecshi Payroll Supervisor 2nd floor School Department 797 Westminster Street Providence, RI 02903 or Monica Hebert Asst. to Payroll Supervisor	Lori Lazzareschi 401-278-0583 Monica Hebert mhebert@providenceri.com 401-278-2826
Manager of Employees Benefits	Margaret Wingate Benefits Department Room 410	401-421-7740 ext 717 MWingate@providenceri.com
Medical Benefits Administration	Susan Brophy Benefits Department 4th floor, Room 410	401-421-7740 ext 278 sbrophy@provideneri.com
Pension & Retirement Issues	Octavio Cunha Pension Administrator 4th floor, Room 409	401-421-7740 ext 296 Ocunha@providenceri.com

CITY OF PROVIDENCE
Angel Taveras, Mayor

CITY OF PROVIDENCE

HOLIDAY SCHEDULE 2013

New Year's Day	Tuesday	January 1, 2013
Martin Luther King, Jr. Day	Monday	January 21, 2013
President's Day	Monday	February 18, 2013
Memorial Day	Monday	May 27, 2013
Independence Day	Thursday	July 4, 2013
Victory Day	Monday	August 12, 2013
Labor Day	Monday	September 2, 2013
Columbus Day	Monday	October 14, 2013
Veteran's Day	Monday	November 11, 2013
Thanksgiving Day	Thursday	November 28, 2013
Day after Thanksgiving	Friday	November 29, 2013
Christmas Day	Wednesday	December 25, 2013

The following ½ days may be provided:

Tuesday, December 24, 2013 - Christmas Eve

Tuesday, December 31, 2013 - New Year's Eve

NOTE: If a holiday falls on a Saturday, the city celebrates it on Friday; if a holiday falls on a Sunday, the City Celebrates it on Monday.

Election Day is a holiday even years only

HUMAN RESOURCES
Providence City Hall | 25 Dorrance Street, Room 401, Providence, Rhode Island 02903
401 421 7740 ph | 401 273 9510 fax
www.providenceri.com

CITY OF PROVIDENCE

Angel Taveras, Mayor

INFORMATION TECHNOLOGY POLICY

(Applies to computers, printers and other peripherals, programs, data, local and wide area networks, email and the internet)

City information technology resources ("City IT resources") include computers, printers and other peripherals, programs, data, local and wide area networks, email and the internet. This document formalizes the policy for employees, interns and contractors ("users") of the City of Providence on the use of information technology resources ("City IT resources"). This policy shall also apply to access to City resources from personal computers or mobile devices.

Using any City IT resources constitutes acceptance of the terms of this policy and any corresponding policies such as those prohibiting harassment, discrimination, offensive conduct or inappropriate behavior.

1. User Responsibilities

It is the responsibility of any person using City IT resources to read, understand, and comply with this policy. Users are expected to exercise reasonable judgment in interpreting this policy and making decisions about the use of City IT resources.

Failure to observe this policy may subject individuals to disciplinary action, up to and including termination of employment.

Any person with questions regarding the application or meaning of this policy should seek clarification from appropriate management.

2. Acceptable Uses

The City firmly believes that IT resources empower users and help them deliver better services at lower costs. Therefore, employees and contractors are encouraged to use City IT resources appropriately to the fullest extent in furtherance of the City's goals and objectives.

3. Unacceptable Uses of City IT Resources

Unless such use is reasonably related to a user's job, it is unacceptable for any person to use City IT resources:

- in furtherance of any illegal act, including violation of any criminal or civil laws or regulations, whether state or federal
- for any use that causes interference with or disruption of network users and resources, including but not limited to propagation of computer viruses or other harmful programs
- for any political purpose
- for any religious purpose
- for any commercial purpose
- to solicit or proselytize for outside organizations or any other non-job-related solicitation
- to send threatening or harassing messages, whether sexual or otherwise
- to access or share sexually explicit, obscene, or otherwise inappropriate materials
- to infringe any intellectual property rights
- to gain, or attempt to gain, unauthorized access to any computer or network
- to intercept communications intended for other persons
- to misrepresent either the City or a person's role at the City
- to distribute chain letters
- to access online gambling sites
- to libel or otherwise defame any person
- to play or distribute pranks that can reasonably be expected to adversely affect any employee's job performance or workplace conditions
- to access online social networking or dating sites, such as Match, Facebook, MySpace or Twitter
- to access, install or use computer games

The City of Providence reserves and intends to exercise the right to review, audit, intercept, access and disclose all messages created, received or sent over the electronic mail system for any purpose. The City reserves the right to block or restrict access to or from public websites or non-City email accounts that violate this policy.

4. Data Confidentiality

In the course of performing one's job, City employees and contractors often have access to confidential or proprietary information, such as personal data about identifiable individuals or commercial information about business organizations.

- Under no circumstances is it permissible for employees or contractors to acquire access to confidential data unless such access is a necessary job requirement.
- Under no circumstances shall employees or contractors disseminate any confidential information that they have rightful access to, unless such dissemination is a necessary job requirement.

5. Copyright Protection
Computer programs and data are valuable intellectual property. Software publishers can be very aggressive in protecting their property rights from infringement. Legal protections also exist for information published on the internet, such as the text and graphics on a web site. It is important that users respect the rights of intellectual property owners and exercise care and judgment when copying or distributing computer programs or information that could reasonably be expected to be copyrighted.

Any person with questions concerning possible violation of copyright or intellectual property rights should seek clarification from the City IT Department.

6. Network Integrity and Security
Users should exercise reasonable precautions in order to prevent the introduction of a computer virus into the local or wide area networks. While virus scanning software is used to check any software downloaded from the internet or obtained from any questionable source, it is not foolproof. Certain precautions should be taken:

- Executable files (program files that end in ".exe") should not be stored on or run from network drives.
- Emails from unknown senders, particularly with attachments, should be deleted without opening.

Most desktop computers are connected to a local area network, supporting most other computers in city government. Users should take the following precautions to avoid compromising the security of the network:

- Users should never share their passwords with anyone else.
- Users should promptly notify City IT personnel if they suspect their passwords have been compromised.
- The password used for City network access should not be used for any personal account.
- Users should either log off the network or lock their account when leaving computers unattended for an extended period of time.
- Users should be wary of email solicitations requesting passwords for work or personal accounts/applications, and contact Agency IT personnel if they receive such a solicitation.

Applications which consume high network or server resources or internet bandwidth, disrupt other users' network access, or degrade network performance, may be blocked. If a website or application is unavailable, but required for business use, notify City IT personnel.

7. Email

Format:

- Because email addresses identify the organization that sent the message (yourname@providenceri.com), users should consider email messages to be the equivalent of letters sent on official letterhead.
- All emails should be written in a professional and courteous tone.
- Emails can be stored, copied, printed, or forwarded by recipients. Therefore, users should not write anything in an email message that they would not put into an official memorandum.

Use:

- Users are prohibited from using their work email address for
    - personal correspondence
    - commercial ventures
    - religious or political causes
    - personal subscriptions, purchases or accounts.
- Users should not send electronic mail to all other employee users through the use of the "Everyone" address group unless expressly authorized by management to do so.
- All emails sent and received through work email are stored by the City and considered the property of the City.

Content:

- The email system shall not be used to harass, intimidate, ridicule, embarrass or discriminate against any individual or group. Use of the City Email system to create or forward intimidating, harassing or offensive and disruptive messages may be grounds for discipline up to and including termination.
- The email system is not to be used to create any offensive or disruptive messages. This includes, but is not limited to:
    - Sexually explicit messages;
    - Messages which contain derogatory, gender-specific comments;
    - Messages containing racial, ethnic, sexual orientation, religious or other slurs;
    - Messages that contain profane or abusive language;
    - Messages which stereotype, harass or ridicule based on:
        - Race
        - Color
        - Religion
        - Country of Origin (or language(s) a person speaks)
        - Gender
        - Gender Identity
        - Sexual Orientation
        - Age
        - Disability – whether physical or mental

Content: (continued)

- Veteran Status
- Marital Status
- Pregnancy status;

- Messages that harass, make fun of, or gossip about another individual (even if not based upon the above classifications);
- Messages that discuss a person's genetic information;
- Messages that offensively address someone's political beliefs.

- Users are prohibited from entering into any contracts or agreements on behalf of the City of Providence through electronic mail. Any such contracts or agreements must be executed through normal channels and must be expressly authorized by management.
- The email system shall not be used to send or receive identifiable employee information except for employee information specifically set forth in the Access to Public Records Act (Rhode Island General Law 38-2-2(5)(i)(A)(1).
- Disclosure of any confidential information through electronic mail to any party not entitled to that information is prohibited.

8. No Expectation of Privacy

City IT resources are the property of the City and are to be used in conformance with this policy.

The City retains the right, and when reasonable and in pursuit of legitimate needs for supervision, control, and the efficient and proper operation of the workplace, will exercise the right, to inspect any user's computer, any data contained in it, and any data sent or received by that computer.

Users should be aware that network administrators, in order to ensure proper network operations, routinely monitor network traffic. Use of City IT resources constitutes express consent for the City to monitor and/or inspect any data that users create or receive, any messages they send or receive, and any web sites that they access.

Emails involving any matter in which the City has supervision, control, jurisdiction, or advisory power over may be considered public records in accordance with the Rhode Island Access to Public Records Act and have the potential to be released to the public.

9. Social Networking and Publication

Users should recognize that they are representatives of the City, both in their professional capacity and, to the extent they are associated with this administration, in their personal life. Careful consideration should be taken when referencing the City of Providence, individual departments, coworkers or business topics in public forums or social networks. Users are reminded that messages disseminated through the internet may be captured, forwarded and put to unintended use by others and, once disseminated, cannot be recalled. *(Rev'd 11.1.11)*

CITY OF PROVIDENCE SEXUAL HARASSMENT POLICY

Sexual harassment is a form of discrimination and violates the following federal, state and local laws:

- Title VII of the Civil Rights Act of 1964 as amended in 1972.
- Rhode Island Fair Employment Practices Act, and the
- City of Providence's Anti-Discrimination Ordinance

The City of Providence believes that every employee is entitled to a working environment free from sexual harassment or offensive conduct of a sex-oriented or sex based nature regardless of its form or manner. Sexual harassment, both in general and as defined in this policy, is unlawful conduct that will not be tolerated by the City of Providence. Offensive or inappropriate sexual behavior at work, including but not limited to, unwelcome sexual advances, request for sexual favors or other verbal or physical acts of a sexual or sex based nature where (a) submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment and/or (b) such conduct interferes with an individual's work performance or creates an intimidating, hostile or offensive working environment, is conduct which the City of Providence considers to be sexual harassment and is strictly prohibited. All employees must avoid any act or conduct which could be viewed by any other individual as sexual harassment.

The City of Providence considers the following identified conduct to represent some examples of the types of acts which violate the City of Providence's Sexual Harassment Policy. This list is neither exhaustive nor all-inclusive.

- Physical assaults of a sexual nature such as: rape, sexual battery, molestation or attempts to commit these assaults and/or intentional physical conduct which is sexual in nature, such as touching, pinching, patting, grabbing, brushing against or poking any other employee's body without the employee's permission.

- Unwanted sexual advances, propositions or other sexual comments such as: sexually-oriented gestures, noises, remarks, jokes or comments about a person's sexuality or sexual experience directed at or made in the presence of any employee who indicates or has indicated in any way that such conduct in his/her presence is unwelcome and/or preferential treatment or promises of preferential treatment to an employee for submitting to sexual conduct, or intentionally making the performance of an employee's job difficult because of that employee's sex.

- Sexual or discriminating displays or publications anywhere in the workplace by employees such as: displaying pictures, posters, calendars, graffiti, objects, written or reading materials or any other material that is sexually suggestive, sexually demeaning or pornographic, or possessing in the work environment any of these materials.

COMPLAINT PROCEDURE

The City of Providence has established a convenient, confidential and reliable mechanism for reporting incidents of sexual harassment and/or retaliation. The City of Providence designates the Equal Employment Opportunity and Affirmative Action Officer to serve as its Investigative Officer for sexual harassment issues. If you have a complaint of sexual harassment and/or retaliation, you should contact the Equal Employment Opportunity and Affirmative Action Officer at (401) 421-7740, Extension 250. The Investigative Officer may appoint a designee to assist him/her in handling sexual harassment/retaliation complaints.

Complaints of sexual harassment and/or retaliation will be accepted in writing or verbally. All complaints will be taken seriously and investigated expeditiously. A complaint need not be limited to someone who was the target of harassment and/or retaliation. The Investigative Officer will produce a written report, which, together with the investigation file, will be discussed with the complainant within a reasonable period of time. The Investigative Officer will have the duty to immediately bring all sexual harassment and/or retaliation complaints to the confidential attention of his/her supervisor, manager or the Mayor.

Only those who have an immediate need to know, including the Investigative Officer, the alleged target of harassment and/or retaliation, witnesses to the conduct, and the alleged harasser, will or may find out the identity of the complainant. All individuals contacted in the course of the investigation will be advised that all retaliation or reprisal will constitute a separate actionable offense for which penalties may be implemented under this Policy.

An employee who believes that he/she has been a victim of sexual harassment can also contact the Rhode Island Commission for Human Rights, 10 Abbott Park Place, Providence, Rhode Island, (401) 222-2661 or the Equal Employment Opportunity Commission, One Congress Street, Boston, Massachusetts, (617) 565-3200 either by phone, sending a written complaint or by going to either Agency in person.

SCHEDULE OF PENALTIES

In determining the ultimate penalty in cases of sexual harassment, the nature and severity of the claimed misconduct, along with any other relevant factors, will be reviewed by management. It is within management's discretion to enact a more severe penalty against an accused harasser than as set forth in the following schedule of penalties.

If the investigation leads to a determination that the allegations of harassment are true the City of Providence will apply the following disciplinary consequences:

- An employee may be immediately discharged for any act of sexual harassment which conduct is proven or otherwise demonstrated to the satisfaction of the Investigative Officer and/or management.

- Acts of sexual harassment which are proven to be non-pervasive will generally result in a warning and/or suspension upon the first offense and discharge upon the second offense.

- In determining the ultimate penalty in cases of sexual harassment, the nature and severity of the claimed misconduct, along with any other relevant factors will be reviewed by management and it is within management's discretion to enact a more severe penalty against an accused harasser than as set forth in this Schedule of Penalties.

RETALIATION

It is unlawful to retaliate or take reprisal in any way against anyone who has articulated any concern about sexual harassment or discrimination. Any form of retaliation against a sexual harassment complainant, alleged harasser or witness cooperating with an investigation of a harassment complaint will result in disciplinary action. The severity of the discipline will be based on the nature and extent of the harassment and retaliation and other relevant factors brought to the attention of the management. The ultimate determination of the appropriate penalty for retaliation will be within the discrection of management.

COOPERATION

An effective sexual harassment policy requires the support of all the City of Providence's personnel. Anyone who engages in sexual harassment and/or retaliation or who fails to cooperate with any City of Providence sponsored investigation may be disciplined by suspension or termination from employment. The City of Providence officials who refuse to implement remedial measures, obstruct remedial efforts or who retaliate against complainants, witnesses or the alleged harasser may be disciplined by suspension or termination from employment.

Rev. July, 1997

CITY OF PROVIDENCE

Angel Taveras, Mayor

CITY OF PROVIDENCE

DRUG FREE WORKPLACE POLICY

Drug use and abuse at the workplace or while on duty are subjects of immediate concern in our society. These problems are extremely complex and ones for which there are no easy solutions. From a safety perspective, the users of drugs may impair the well-being of all employees, the public at large, and result in damage to property. Therefore, it is the policy of the City of Providence that the unlawful manufacture, distribution, dispensation, possession or use of a controlled substance is prohibited in the workplace. Any employee(s) violating this policy will be subject to discipline up to and including termination. An employee may also be discharged or otherwise disciplined for a conviction involving illicit drug behavior, regardless of whether the employee's conduct was detected within employment hours or whether his/her actions were connected in any way with his/her employment. The specifics of this policy are as follows:

1. Any employee who gives or in any way transfers a controlled substance to another person or sells or manufactures a controlled substance while on the premises of the employer will be subject to discipline up to and including termination..

2. The term "controlled substance" means any drugs listed in 21 U.S.C. 812 and other federal regulations. Generally, all illegal drugs and substances are included such as marijuana, heroin, morphine, codeine, or opium additives, LSD, DMT, STP, amphetamines, methamphetamines and barbiturates.

3. Each employee is required by law to inform the City of Providence Personnel or Department Director within five (5) days after he/she is convicted for violation of any federal or state criminal drug statute. A. conviction means finding of guilt (including a plea of nolo contendre) or the imposition of sentence by a judge or jury in any federal or state court.

4. The employer (the hiring authority) will be responsible for reporting conviction (s) to the appropriate federal granting source, within ten (10) days after receiving notice from the employee or otherwise receives actual notice of such a conviction(s). All convictions (s) must be reported in writing to the Office of Personnel within the same time frame.

HUMAN RESOURCES

Providence City Hall | 25 Dorrance Street, Room 401, Providence, Rhode Island 02903

401 421 7740 ph | 401 273 9510 fax

www.providenceri.com

5. If an employee is convicted of violating any criminal drug statute while on duty, he/she will be subject to discipline up to and including termination. Conviction(s) while off duty may result in discipline or discharge.

6. The City of Providence encourages any employee with a drug abuse problem to seek assistance. Should you need more information about the assistance that is available, contact the Personnel Office

7. The Law requires all employees to abide by this policy.

11/93
DD

CITY OF PROVIDENCE

HIPAA Privacy Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice our Privacy Contact is Margaret Wingate, she can be reached at (401) 421-7740 ext. 616 or by e-mail at mwingate@providenceri.com.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present and future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for auditing purposes, for research studies and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice. You can also request a copy of our notice at anytime. For more information about our privacy practices, contact the person listed below.

The Federal regulations that govern the use and disclosure of protected health information may require us to disclose your health information in any of the following situations:

Required By Law. We may use or disclose your protected health information to the extent that law requires the use or disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health. We may disclosure your protected health information for public activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases. We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading disease or condition.

Health Oversight. We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect. We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration. We may disclose your protected health information to a person or company as directed or required by the Food and Drug administration (i) to report adverse events (or similar activities with respect to food of dietary supplements), product defects or problems (including problems with the use or labeling of a product), or biological product deviations, (ii) to track FDA-regulated products, (iii) to enable product recalls, repairs or replacement, or look back (including located and notifying individuals who have received products that have been recalled, withdrawn, or are the subject of look back), or (iv) to conduct post – marketing surveillance.

Legal Proceedings. We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized) in certain conditions, in response to a subpoena, discovery request or other lawful process.

Law Enforcement. We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the promises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation. We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research. We may disclose your protected health information to researchers when their research has been approved by institiutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity. Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security. When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military service. We may also disclose your protected health information to authorized federal official for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation. Your protected health information may be disclosed by us as authorized to comply with workers' Compensation laws and other similar legally established programs.

Inmates. We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

Your Rights

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes,; information complied in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have any questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment

CITY OF PROVIDENCE/ NON-UNION

Product Name: Delta Dental Premier
Plan Type: National Coverage

The information listed here is not a guarantee of payment. Payment is based on the Delta Dental allowance for each procedure. To be covered, services must be dentally necessary and in accordance with Delta Dental's treatment guidelines. All services must be performed in a dental office. These benefits are listed according to the level of coverage (i.e. 100%,80%) . Your group number is 1105-0001 & 1105-0019. Coverage for benefits with time limitations (i.e. 6,12,24,36 or 60 months) is calculated to the exact day.

The annual maximum is:	$2,000.00 per member per calendar year
The annual deductible is:	$0.00
The maximum lifetime cap:	Unlimited

Pretreatment estimates are recommended for underlined procedures.

Plan pays 100%; Member Coinsurance 0%

- Oral exam - once per calendar year performed by a general dentist
- Cleaning - twice per calendar year
- Fluoride treatment - for children under age 19 once per calendar year
- Bitewing x-rays - one set per calendar year
- Complete x-ray series or panoramic film once every 36 months
- Single x-rays as required
- Sealants for children under age 14, once every 24 months on unrestored permanent molars
- Palliative treatment (minor procedures necessary to relieve acute pain) twice per calendar year
- Amalgam (silver) fillings. Composite (white) fillings on front teeth only. For composite fillings on back teeth, the plan pays up to what would have been paid for an amalgam filling. Patient is responsible for the balance up to the dentist's charge.
- Space maintainers once every 60 months for lost deciduous (baby) teeth
- Extractions and other routine oral surgery when not covered by a patient's medical plan
- General anesthesia or intravenous (I.V.) sedation for certain complex surgical procedures
- Root canal therapy
- Repairs to existing partial or complete dentures once per calendar year
- Recementing crowns or bridges once every 60 months
- Rebasing or relining of partial or complete dentures once every 60 months
- Crowns over natural teeth, build ups, posts and cores - replacement limited to once every 60 months

Plan pays 50%; Member Coinsurance 50%

- Periodontal maintenance following active therapy - two per year
- Bridges, build ups, posts and cores, crowns over implants - replacement limited to once every 60 months
- Partial and complete dentures - replacement limited to once every 60 months
- Root planing and scaling once per quadrant every 24 months.
- Osseous (bone) surgery once per quadrant every 24 months (bone grafts are not covered).
- Gingivectomies once per site every 24 months.
- Soft tissue grafts once per site every 60 months
- Crown lengthening once per site every 60 months

Orthodontics:

Plan pays 50%; Member Coinsurance 50%

- Braces and related services for dependent children under the age of 19

Lifetime maximum (orthodontics only) is $2,000.00

Dependent coverage - Dependent children are covered up until the end of the month that they turn age 26.

Group Benefits from The Hartford

Income Protection Benefits

City of Providence

Information About You

Benefits Enrollment Form

Name: 23997-0	Social Security Number / Employee ID Number:
Date of Birth:	Date of Hire:
Earnings:	Location/Department/Division:

Instructions

Please enter all required information clearly so that there will be no question as to your meaning.

- **Step 1:** Please **enter or check** your coverage elections and details. *You may only elect – and will be covered for – levels of coverage included in your employer's contract.*
- **Step 2:** Please **sign, date and return** this form to Human Resources.

Supplemental Life Insurance

You can purchase Supplemental Life Insurance in increments of 1 times your annual Earnings up to 5 times your annual Earnings, rounded to the next higher $1,000. The maximum amount you can purchase cannot be more than 5 times your annual Earnings or $500,000. If you elect an amount that exceeds the guaranteed issue amount of $200,000, you will need to provide evidence of good health that is satisfactory to The Hartford before the excess can become effective.

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	0.0570	0.0540	0.0670	0.0990	0.1520	0.2510	0.4240	0.6860	0.9080	1.4400	1.4400	1.4400

To calculate your Monthly cost, please use the following formula(s):

_____ (Life Benefit Amount) ÷ $1,000 = _____ x _____ (Rate) = $_____ (My Monthly Cost)

☐ I elect to purchase $_____ of Life coverage.

☐ I decline to purchase Life coverage.

Beneficiary Designation

You must select your beneficiary – the person (or more than one person) or legal entity (or more than one entity) who receives a benefit payment if you die while covered by the plans. **This beneficiary designation will be for ALL group life or accidental death insurance coverage issued by The Hartford for you, unless specifically named otherwise.** Please make sure that you also name a contingent beneficiary – who would receive your benefit if your primary beneficiary dies first.

Please make sure your beneficiary designation is clear so that there will be no question as to your meaning. If you name more than one primary or contingent beneficiary, show the percentage of your benefit to be paid to each beneficiary. Please provide all of the information requested below. If your beneficiary is not related either by blood or by marriage, insert the words, "Not Related" as their stated relationship. If you need assistance, contact your benefits administrator or your own legal advisor.

Expertise without equal.
Benefits without burden.℠

Group Benefits from The Hartford

Supplemental Life Insurance

Benefit Highlights for:

City of Providence

What is Supplemental Life insurance?	Supplemental Life Insurance is coverage that you pay for, in addition to any Basic Life Insurance that your employer may provide to you. Life Insurance pays your *beneficiary* (please see below) a benefit if you die while you are covered. This highlight sheet is an overview of your Supplemental Life Insurance. Once a group policy is issued to your employer, a certificate of insurance will be available to explain your coverage in detail.
Why do I need Life Insurance?	Life insurance provides affordable financial security for your loved ones, although when it comes down to it, contemplating some pretty unpleasant things is hard to do. But when you consider the fact that between 1995 and 1997, almost 40% of all deaths that occurred were people between the ages of 25 and 64[1], it's harder to ignore. Especially when your family depends on your income. [1]Death Rates by Age, Sex and Race: 1970 to 1997, U.S. Census Bureau, Statistical Abstract of the United States, 1999, page 95.
Am I eligible?	You are eligible if you are an active full-time employee who works at least 20 hours per week on a regularly scheduled basis.
When can I enroll?	Enrollment in Supplemental Life Insurance is determined by your Employer. As an eligible employee, you are automatically covered by Basic Life Insurance; you do not have to enroll. If you have not already done so, you must designate a beneficiary as described below.
When is it effective	Coverage goes into effect subject to the terms and conditions of the policy. In no case will newly elected benefits become effective sooner than the eligibility date or approval date. You must be Actively at Work with your employer on the day your coverage takes effect.
How much Supplemental Life Insurance can I purchase?	You can purchase Supplemental Life Insurance in increments of 1-5X's your annual earnings. The maximum amount you can purchase cannot be more than $500,000. Earnings are as defined in The Hartford's* contract with your employer.
Am I guaranteed coverage? *(Guaranteed Issue: New Employee)*	When you enroll, you are guaranteed up to $200,000 or 5x's times your salary, whichever is less, of Supplemental Life Insurance – *no medical information is required.* You must provide evidence of insurability and be approved by The Hartford to receive coverage above the guaranteed amount. You may need to complete a *Personal Health Application.* These are available from The Hartford or your employer.

Expertise without equal.
Benefits without burden.℠

What is a beneficiary?	Your beneficiary is the person (or persons) or legal entity (entities) who receives a benefit payment if you die while you are covered by the policy. You must select your beneficiary when you complete your enrollment application; your selection is legally binding.
Are any resources available for beneficiaries?	Beneficiary Assist® provides grief, legal and financial counseling to beneficiaries. The Hartford* offers this program *at no cost* to beneficiaries of any of its group life or accident policies. Services include: unlimited phone contact, assessment and action planning, up to five face-to-face sessions, referrals and more. You will receive more details about Beneficiary Assist® once your enrollment for Supplemental Life Insurance is approved.
Are there other limitations to enrollment?	If you do not enroll within 31 days of your first day of eligibility, you will be considered a "late entrant." Typically, late entrants must need to show evidence of insurability and may be responsible for the cost of physical exams or other associated costs if they are required. This coverage, like most group benefit insurance, requires that a certain percentage of eligible employees participate. If that group participation minimum is not met, the insurance coverage that you have elected may not be in effect.
Does my coverage reduce as I get older?	Your Supplemental Life coverage is reduced by 50% @ age 65. All coverage cancels at retirement.
Can I keep my Supplemental Life Insurance coverage if I leave my employer?	Yes, based on your contract, you have the option of: ▪ Converting your group Supplemental Life Insurance to your own individual policy. AND/OR If you leave your employer, Portability is an option that allows you to continue your Life insurance coverage. To be eligible, you must terminate your employment prior to Social Security Normal Retirement Age. This option allows you to continue all or a portion of your Supplemental Life Insurance coverage under a separate Portability term policy. Portability is subject to a minimum of $5,000 and a maximum of $250,000 and does not include dependent coverage. To elect Portability, you must apply and pay the premium within 31 days of the termination of your Supplemental Life Insurance. Evidence of Insurability will not be required.

Important Details

As is standard with most term life insurance, Supplemental Life Insurance coverage includes certain limitations and exclusions:

- Death by suicide (two years) – (applies to Supplemental only)

Other exclusions may apply depending upon your coverage. Once a group policy is issued to your employer, a certificate of insurance will be available to explain your coverage in detail.

This Benefit Highlights Sheet is an overview of the Life Insurance being offered and is provided for illustrative purposes only and is not a contract. It in no way changes or affects the policy as actually issued. Only the insurance policy issued to the policyholder (your employer) can fully describe all of the provisions, terms, conditions, limitations and exclusions of your insurance coverage. In the event of any difference between the Benefit Highlights Sheet and the insurance policy, the terms of the Insurance policy apply.

Union Handout

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

▶START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	Zip Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	E-mail Address	Telephone Number
	___-___-___		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

☐ A citizen of the United States

☐ A noncitizen national of the United States *(See instructions)*

☐ A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "N/A" in this field. *(See instructions)*

For aliens authorized to work, provide your Alien Registration Number/USCIS Number OR Form I-94 Admission Number:

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. *(See instructions)*

3-D Barcode
Do Not Write in This Space

Signature of Employee:	Date *(mm/dd/yyyy)*:

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator:			Date *(mm/dd/yyyy)*:
Last Name *(Family Name)*	First Name *(Given Name)*		
Address *(Street Number and Name)*	City or Town	State	Zip Code

STOP *Employer Completes Next Page* STOP

CITY OF PROVIDENCE
Angel Taveras, Mayor

WORKERS' COMPENSATION INFORMATION IS REQUIRED ONLY AFTER A JOB OFFER HAS BEEN MADE

Are you or have you collected Workers' Compensation benefits for a job related injury?

Yes_____ or No_____ If yes, please give the date of your injury, nature of the injury, period of disability and present status of your injury.

_____

_____

_____

NOTICE

Please take note that under RI General Laws #28-35-57.1, Workers' Compensation claims shall be denied from the date an employee commences employment for a period of two (2) years if an employee has willfully provided false information or intentionally failed to disclose his or her workers' compensation history to the employer on an application requesting such information if the information relates to the injury, which is the basis of the new claim for compensation. Therefore, please take your time in completing and signing this questionnaire. If you need additional time to obtain the necessary information, you may request it.

CERTIFICATION

I hereby certify that the medical history information listed above is accurate to the best of my knowledge and belief.

_____ _____

Employee's signature Date

HUMAN RESOURCES
Providence City Hall | 25 Dorrance Street, Room 401, Providence, Rhode Island 02903
401 421 7740 ph | 401 273 9510 fax
www.providenceri.com

CITY OF PROVIDENCE

Angel Taveras, Mayor

DRUG FREE WORKPLACE POLICY ACKNOWLEDGEMENT
NEW HIRES

I, _____, an employee with the City of Providence hereby acknowledge That I have received a copy of the City's Policy regarding the maintenance of a Drug Free Policy Workplace. I have been informed that the unlawful manufacture, distribution, dispensation, possession or use of a controlled substance (to include but not limited to such drugs as marijuana, heroin, cocaine, PCP and crack, and may also include legal drugs which may be prescribed by a licensed physician if they are abused), is prohibited on the City's premises or while conducting city business. I also understand that convictions involving illicit drug behavior while off duty may result in disciplinary action. I acknowledge that I must report for work in fit condition to perform my duties. Violation of this policy make me subject to discipline up to and including termination. As a condition of City employment, I must abide by the terms of this policy and I will report to the employer any criminal drug conviction no later than five (5) days after such conviction. I realize that federal law mandates the employer to communicate this conviction to the appropriate federal agency under certain circumstances.

In accordance with the Drug Free Workplace Policy I certify that as a condition of my employment, I do not currently use illegal drugs.

_____ _____

Employee Date

COMMENTS IF ANY:

_____ _____

Department/Agency Signature Date policy reviewed with employee

5/94

HUMAN RESOURCES

Providence City Hall | 25 Dorrance Street, Room 401, Providence, Rhode Island 02903

401 421 7740 ph | 401 273 9510 fax

www.providenceri.com

CITY OF PROVIDENCE

Angel Taveras, Mayor

City of Providence Sexual Harassment Policy Acknowledgment
New Hires

I,_____, an employee with the City of Providence hereby acknowledge that I have received and read a copy of the City's Sexual Harassment Policy. Sexual Harassment is a form of discrimination and violates the following feeder, state and local laws:

- Title VII of the Civil Rights Act of 1964 as amended in 1972
- Rhode Island Fair Employment Practices Act, and the
- City of Providences Anti-Discrimination Ordinance

I have been informed that it is the policy of the City of Providence to prohibit sexual harassment of an employee by another employee or supervisor. In addition every employee is entitled to a working environment free from sexual harassment or offensive conduct of a sex-oriented or sex based nature regardless of its form or manner. Sexual harassment, both in general and as defined in this policy is unlawful conduct that will not be tolerated by the City of Providence. Offensive or inappropriate sexual behavior at work, including but not limited to, unwelcome sexual advances, request for sexual favors or other verbal or physical acts of a sexual or sex based nature where (a) submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment and/or (b) such conduct interferes with an individual's work performance or creates an intimidating, hostile of offensive working environment, is conduct which the City of Providence considers to be sexual harassment and is strictly prohibited. All employees must avoid any act or conduct which could be viewed by any other individual as sexual harassment. I also understand that if I'm a victim sexual harassment I can make a formal complaint to the City **EEO/AA Officer at 421-7740 ext 250,** or I can contact the Rhode Island Commission for Human Rights, 10 Abbott Park Place, Providence, Rhode Island 277-2661 or the Equal Employment Opportunity Commission, One Congress Street, Boston, Massachusetts, (617) 565-3200 either by phone, sending a written complaint or by going to either agency in person. I acknowledge that I as well as all my co-workers, supervisors, and colleagues are all entitled to a working environment free from sexual harassment or offensive conduct of a sex oriented or sex based nature. Violation of this policy make me subject to discipline up to and including termination. As a condition of City employment, I must abide by the terms of this policy and I will report to the employer any sexual harassment complaint I may have or see by my co-workers.

_____ _____

EMPLOYEE SIGNATURE DATE

_____ _____

DEPARTMENT/SIGNATURE DATE

HUMAN RESOURCES

Providence City Hall | 25 Dorrance Street, Room 401, Providence, Rhode Island 02903

401 421 7740 ph | 401 273 9510 fax

www.providenceri.com

CITY OF PROVIDENCE
Angel Taveras, Mayor

EQUAL EMPLOYMENT OPPORTUNITY SURVEY

The City of Providence is required by Equal Employment Opportunity Commission (EEOC) and the Department of Housing and Urban Development (HUD) regulations to collect and maintain certain information in support of our Equal Employment Opportunity Program.

THE INFORMATION REQUESTED ON THIS SURVEY IS STRICTLY FOR EEO RECORD KEEPING PURPOSES ONLY.

NAME:_____
(LAST) (FIRST) (MIDDLE)

ADDRESS:_____

_____
CITY STATE ZIP CODE

SS# :_____ TELEPHONE#_____

D.O.B.:_____

GENDER: MALE :_____ FEMALE:___

RACE:

WHITE:_____

BLACK:_____

HISPANIC:_____

ASIAN & PACIFIC ISLANDER:_____

AMERICAN INDIAN/ALASKAN NATIVE:_____

HUMAN RESOURCES
Providence City Hall | 25 Dorrance Street, Room 401, Providence, Rhode Island 02903
401 421 7740 ph | 401 273 9510 fax
www.providenceri.com

CITY OF PROVIDENCE

Angel Taveras, Mayor

Emergency Contact Information Form

Your Name:_____
Last First Middle

Address:_____
Street City State ZIP

Cell phone:_____ Home phone:_____

Work Phone:_____ E-mail:_____

Person to contact in case of an Emergency:_____
Last First

Cell Phone:_____ Home Phone:_____

Work Phone:_____

If unavailable 2nd Contact Name:_____
Last First

Cell Phone:_____ Home Phone:_____

Work Phone:_____

Comments: *(include any special medical or personal information you would want an emergency care provider to know – or special contact information)*

_____

_____

_____

HUMAN RESOURCES

Providence City Hall | 25 Dorrance Street, Room 401, Providence, Rhode Island 02903

401 421 7740 ph | 401 273 9510 fax

www.providenceri.com

Form W-4 (2013)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2013 expires February 17, 2014. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,000 and includes more than $350 of unearned income (for example, interest and dividends).

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the Personal Allowances Worksheet below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2013. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	A	
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	B	
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C	
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	D	
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under Head of household above)	E	
F	Enter "1" if you have at least $1,900 of **child or dependent care expenses** for which you plan to claim a credit (**Note.** Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F	
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $65,000 ($95,000 if married), enter "2" for each eligible child; then less "1" if you have three to six eligible children or less "2" if you have seven or more eligible children. • If your total income will be between $65,000 and $84,000 ($95,000 and $119,000 if married), enter "1" for each eligible child	G	
H	Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ▶	H	

For accuracy, complete all worksheets that apply.

- If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are married and you and your spouse both work and the combined earnings from all jobs exceed $40,000 ($10,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.

---------- Separate here and give Form W-4 to your employer. Keep the top part for your records. ----------

Form **W-4** — Department of the Treasury, Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.

OMB No. 1545-0074

2013

1 Your first name and middle initial	Last name	2 Your social security number
Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code	4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ ☐	

5	Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)	5
6	Additional amount, if any, you want withheld from each paycheck	6 $
7	I claim exemption from withholding for 2013, and I certify that I meet both of the following conditions for exemption. • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here ▶	7

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) ▶ Date ▶

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

Delta Dental of Rhode Island
P.O. Box 1517
Providence, RI 02901-1517
800-84-DELTA

Please print

Employer Group Name	Delta Dental Group Number	Date of Hire	Location No. (if applicable)

Social Security No. / Subscriber I.D. No.	Subscriber Name: First - Last
Date of Birth - MM/DD/YYYY	Street Address / P.O. Box No.

Effective Date of Change	Apt. No.	City	State	Zip

REASON FOR CHANGE

- ____ Open Enrollment
- ____ New Hire/Re-hire
- ____ Marriage
- ____ Divorce
- ____ Birth or Adoption
- ____ Workers' Compensation
- ____ Return From Leave of Absence
- ____ Dependent's Loss of Coverage
- ____ Full-Time/Part-Time Status
- ____ Death of a Member

ACTION CODE (Check One) *(Changes must be made on the first of the month)*
Explain in "Other Remarks" if necessary.

ADDITIONS:

- ____ New Subscriber
- ____ Add Dependent to Existing Family Coverage
- ____ Reinstatement

TERMINATION:

- ____ Remove Subscriber
- ____ Remove Dependent/Student (List dependent name.)

STATUS CHANGE:

- ____ Individual to Family
- ____ Family to Individual
- ____ Name / Address Change
- ____ Transfer from Sublocation #_____ to #_____

COBRA:

- ____ Reinstatement of Subscriber
- ____ Add Dependent: - (From Prior Subscriber ID #_____)

DEPENDENT INFORMATION

First Name Only If last name differs, please indicate in "other remarks" below.	Date of Birth	Relationship	Check box if full-time student over 19. Group must have student rider.
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐

☐ Corrections / Other Remarks (Please Explain)

Type of Coverage: (Check One) ☐ Individual ☐ Family

COORDINATION OF BENEFITS

DENTAL — Are You or Any of Your Dependents Covered by Another Dental Plan? ☐ No ☐ Yes If Yes, Please Complete the Section Below.

Other Dental Insurance Name:_____ Type of Coverage: ☐ Individual ☐ Family

Other Dental Insurance Address:_____

Employer Name Through Which You/Your Dependents Have Other Insurance:_____

Group Policy No.	Policyholder Name	Policyholder ID No.

MEDICAL — Are You or Any of Your Dependents Covered by A Medical Plan? ☐ No ☐ Yes If Yes, Please Complete the Section Below.

Name of Medical Insurance Company/HMO:_____ Type of Coverage: ☐ Individual ☐ Family

Name of Health Plan/Type of Coverage:_____

Employer Name Through Which You/Your Dependents Have Other Insurance:_____

Group Policy No.	Policyholder Name	Policyholder ID No.

I certify that all information is true and correct to the best of my knowledge. Also, I understand that the effective date and termination date of my membership will be determined by my employer or plan sponsor in accordance with the underwriting guidelines of Delta Dental. In addition, if my employer requires employee contributions for this coverage, I authorize the deductions of these amounts from my wages periodically.

Employee Signature _____ Date _____ Benefits Administrator Authorization _____ Date _____

DELTA DENTAL

Benefit Highlights

CITY OF PROVIDENCE/ LOCAL 1033

Product Name: Delta Dental Premier
Plan Type: National Coverage

The information listed here is not a guarantee of payment. Payment is based on the Delta Dental allowance for each procedure. To be covered, services must be dentally necessary and in accordance with Delta Dental's treatment guidelines. All services must be performed in a dental office. These benefits are listed according to the level of coverage (i.e. 100%,80%) . Your group number is **1105-0013 & 1105-0020**. **Coverage for benefits with time limitations (i.e. 6,12,24,36 or 60 months) is calculated to the exact day.**

The annual maximum is:	$2,000.00 per member per calendar year
The annual deductible is:	$0.00
The maximum lifetime cap:	Unlimited

Pretreatment estimates are recommended for underlined procedures.

Plan pays 100%; Member Coinsurance 0%

- Oral exam - once per calendar year performed by a general dentist
- Cleaning - twice per calendar year
- Fluoride treatment - for children under age 19 once per calendar year
- Bitewing x-rays - one set per calendar year
- Complete x-ray series or panoramic film once every 36 months
- Single x-rays as required
- Sealants for children under age 14, once every 24 months on unrestored permanent molars
- Palliative treatment (minor procedures necessary to relieve acute pain) twice per calendar year
- Amalgam (silver) fillings. Composite (white) fillings on front teeth only. For composite fillings on back teeth, the plan pays up to what would have been paid for an amalgam filling. Patient is responsible for the balance up to the dentist's charge.
- Space maintainers once every 60 months for lost deciduous (baby) teeth
- Extractions and other routine oral surgery when not covered by a patient's medical plan
- General anesthesia or intravenous (I.V.) sedation for certain complex surgical procedures
- Root canal therapy
- Repairs to existing partial or complete dentures once per calendar year
- Recementing crowns or bridges once every 60 months
- Rebasing or relining of partial or complete dentures once every 60 months
- Crowns over natural teeth, build ups, posts and cores - replacement limited to once every 60 months

Plan pays 50%; Member Coinsurance 50%

- Periodontal maintenance following active therapy - two per year
- Bridges, build ups, posts and cores, crowns over implants - replacement limited to once every 60 months
- Partial and complete dentures - replacement limited to once every 60 months
- Root planing and scaling once per quadrant every 24 months.
- Osseous (bone) surgery once per quadrant every 24 months (bone grafts are not covered).
- Gingivectomies once per site every 24 months.
- Soft tissue grafts once per site every 60 months
- Crown lengthening once per site every 60 months

Orthodontics:

Plan pays 50%; Member Coinsurance 50%

- Braces and related services for dependent children under the age of 19

Lifetime maximum (orthodontics only) is $2,000.00

Dependent coverage - Dependent children are covered up until the end of the month that they turn age 26.

Group Member Application for Health and Dental Insurance

Blue Cross Blue Shield of Rhode Island

Please be sure ALL information below is complete to avoid delays in processing.
Please print clearly using blue or black ink.

Section 1 Employer Information (To be completed by plan administrator)

Group name		Effective date (mm/dd/yyyy)	Date of hire (mm/dd/yyyy)
Group number	Dept. number		

Choose one:
- ☐ Open enrollment
- ☐ New hire
- ☐ COBRA
- ☐ Loss of coverage (HIPAA Certificate of Creditable Coverage required)
- ☐ Other _____

or

Add dependent(s)
- ☐ Spouse
- ☐ Dependent

Date of event (mm/dd/yyyy) _____
(Must add within 31 days of marriage, birth, or adoption of dependent.)

Section 2 Employee Information

Last name	Suffix	First name	M.I.

Home address (street/apartment number)	City/town	State	ZIP code

Mailing address (street/apartment number, city/town, state, ZIP code—if different from above)

Date of birth (mm/dd/yyyy)	Gender ☐ M ☐ F	Social Security number (xxx-xx-xxxx)*	What is your primary language spoken?

Home phone number	Cell phone number

Marital status (please check one)
☐ Single ☐ Married ☐ Divorced ☐ Common law ☐ Other _____

Primary care physician (PCP) name, street, city/town, state and ZIP code (mandatory for BlueCHiP plans)

Are you a current patient? ☐ Yes ☐ No	Provider ID

Section 3 Health Plan Options*

Plan type

☐ Medical: ☐ Enrollee only ☐ Enrollee and spouse ☐ Enrollee and child(ren) ☐ Enrollee, spouse and child(ren)

☐ Dental: ☐ Enrollee only ☐ Enrollee and spouse ☐ Enrollee and child(ren) ☐ Enrollee, spouse and child(ren)

*Social Security number is required in order to comply with the reporting requirements of the Mandatory Insurance Reporting Law. See www.cms.hhs.gov/MandatoryInsRep/

What product(s) are you selecting?

- ☐ HealthMate Coast-to-Coast _____
- ☐ HealthMate Coast-to-Coast HDHP _____
- ☐ BlueSolutions for HRA _____
- ☐ BlueSolutions for HSA _____
- ☐ BlueCHiP _____
- ☐ Classic _____
- ☐ Dental _____

Section 4 Spouse information

Last name	Suffix	First name	M.I.

Home address (street/apartment number, city/town, state, ZIP code—if different from employee)

Date of birth (mm/dd/yyyy)	Gender ☐ M ☐ F	Social Security number (xxx-xx-xxxx)*	What is your primary language spoken?

Home phone number	Cell phone number

Primary care physician (PCP) name, street, city/town, state and ZIP code (mandatory for BlueCHiP plans)

Are you a current patient? ☐ Yes ☐ No	Provider ID

Section 5 Dependent information (If necessary, please attach dependent addendum.)

Dependent #1 First name	Last name	M.I.	Relationship ☐ Son ☐ Daughter

Date of birth (mm/dd/yyyy)	Social Security number (xxx-xx-xxxx)*

Primary care physician (PCP) name, street, city/town, state and ZIP code (mandatory for BlueCHiP plans)

Are you a current patient? ☐ Yes ☐ No	Provider ID

Dependent #2 First name	Last name	M.I.	Relationship ☐ Son ☐ Daughter

Date of birth (mm/dd/yyyy)	Social Security number (xxx-xx-xxxx)*

Primary care physician (PCP) name, street, city/town, state and ZIP code (mandatory for BlueCHiP plans)

Are you a current patient? ☐ Yes ☐ No	Provider ID

*Social Security number is required in order to comply with the reporting requirements of the Mandatory Insurance Reporting Law. See www.cms.hhs.gov/MandatoryInsRep/

Dependent #3 First name	Last name	M.I.	Relationship ☐ Son ☐ Daughter
Date of birth (mm/dd/yyyy)	Social Security number (xxx-xx-xxxx)*		
Primary care physician (PCP) name, street, city/town, state and ZIP code (mandatory for BlueCHiP plans)			
Are you a current patient? ☐ Yes ☐ No	Provider ID		

Dependent #4 First name	Last name	M.I.	Relationship ☐ Son ☐ Daughter
Date of birth (mm/dd/yyyy)	Social Security number (xxx-xx-xxxx)*		
Primary care physician (PCP) name, street, city/town, state and ZIP code (mandatory for BlueCHiP plans)			
Are you a current patient? ☐ Yes ☐ No	Provider ID		

☐ Check here if Group Dependent Addendum form will be attached.

Section G — Other Insurance

Are you or any of your dependents covered by other insurance? ☐ Yes ☐ No	Name of other insurance company and name(s) of covered person(s):
	Covered person 1 _____
	Insurance company _____
	Member ID #1 _____
	Covered person 2 _____
	Insurance company _____
	Member ID #2 _____

What is the name of your prior health insurance carrier?	What was the date of termination? (mm/dd/yyyy)
_____	_____
_____	If loss of coverage, please attach a copy of the Certificate of Creditable Coverage.

Is anyone named in this application eligible for Medicare? ☐ Yes ☐ No	If yes, name of eligible person _____	
Is the eligible person ☐ Over 65 ☐ Disabled	Retired date (if applicable) _____	Medicare number ___-___-____-____
Effective dates: (mm/dd/yyyy) Part A (hospital): _____	Part B (medical): _____	

*Social Security number is required in order to comply with the reporting requirements of the Mandatory Insurance Reporting Law. See www.cms.hhs.gov/MandatoryInsRep/

Section 7 Signature

By signing this form,

1.) I permit any physician, hospital, or other medical facility or provider to release medical records and reports to Blue Cross & Blue Shield of Rhode Island (BCBSRI) for me and my minor dependents. I permit BCBSRI to use such medical records and reports for purposes of:

- claims payment,
- case management,
- coordination of benefits,
- any other purpose directly related to the administration of BCBSRI, and
- inviting me and my enrolled members to take part in medical, disease, or case management programs.

This approval shall end two (2) years from the issue date of this plan, unless canceled sooner.

2.) I certify the information is true and complete to the best of my knowledge.

SIGN HERE ☞

Signature of applicant _____ Date

Application rec'd date_____ ID #_____

Blue Cross Blue Shield of Rhode Island

www.BCBSRI.com

500 Exchange Street • Providence, RI 02903-2699

Public Employees' Local Union 1033

410 South Main Street
Providence, Rhode Island 02903-7124
Tel. (401) 331-1033
Fax (401) 421-0244

DUES DEDUCTION AUTHORIZATION
MANDATORY THAT ALL SECTIONS BE COMPLETED

Please Print **LAST**	**FIRST**	**MIDDLE INITIAL**

ADDRESS: STREET	**CITY/STATE**	**ZIP CODE**

TELEPHONE #
(HOME)_____ **(WORK)** _____ **(CELL)** _____

E-MAIL
(HOME)_____ **(WORK)**_____

DEPT:_____ **POSITION:**_____

DATE OF BIRTH: _____/_____/_____ **SOCIAL SECURITY NO.** _____-____-_____

TO: CITY OF PROVIDENCE, PROVIDENCE, RI: (WHITE AND BLUE COLLAR)
BI-WEEKLY

This is to authorize you to deduct from my weekly salary the sum of TWENTY-NINE AND 58/100 ($29.58) for union dues in accordance with the Collective Bargaining Agreement by and between the Rhode Island Laborers' District Council, on behalf of Local Union 1033 and the City of Providence payable to the Secretary-Treasurer of Local Union 1033.

This authorizes Local Union 1033 to file this card with the City of Providence on behalf of the undersigned and is to be effective as soon as received by CITY OF PROVIDENCE.

DATED:_____ _____
Signature of Employee

NOTE: Dues, contributions or gifts to Local Union 1033 are not deductible as charitable contributions for federal income tax purposes. Dues paid to Local Union 1033, however, may qualify as business expenses and may be deductible in limited circumstances subject to various restrictions imposed by the Internal Revenue Service.

DATED:_____ _____
Signature of Employee

RHODE ISLAND LABORERS' PUBLIC EMPLOYEES
POLITICAL ACTION COMMITTEE DEDUCTION

I authorize the Employer to deduct the sum of two cents ($.02) per hour for each hour worked or paid for as a voluntary contribution to the Rhode Island Laborers' Public Employees Political Action Committee (RILPEPAC), which I understand constitutes a separate aggregate fund used for the purposes allowed under the provisions of Rhode Island law.

Such deductions shall be made from my earned pay on each regularly scheduled pay day and shall be remitted to the designated depository at the same time as employer contributions are remitted to Union Benefit Funds.

This authorization shall become operative upon the date of each collective bargaining agreement entered into between my employer and the Union or the date in which my Union transmits this Authorization Form, whichever is later and shall be irrevocable for a period of one (1) year, or until termination of the collective bargaining agreement in existence between my employer and the Union, whichever occurs sooner; and I agree and direct that this authorization shall be automatically renewed and shall be irrevocable for successive periods of one (1) year each, or for such terms of successor collective bargaining agreements between my employer and the Union, whichever shall be shorter, unless written notice is given by me to my Employer and the Local Union not more than twenty (20) days and not less than ten (10) days prior to the expiration of each period of one (1) year, or of each applicable collective bargaining agreement between my employer and the Union, whichever occurs sooner.

The above revocation must be in writing, bear the date and my signature, and be delivered to the officers of the Local Union of which I am a member and to the Employer with whom I am then currently employed.

Dues, contributions or gifts to the Local Union are not deductible as charitable contributions for federal income tax purposes. Dues paid to the Local Union, however, may qualify as business expenses, and may be deductible in limited circumstances subject to various restrictions imposed by the Internal Revenue Service.

_____
Employee Signature

_____
Printed Name

_____
Social Security Number

_____
Address City or Town State and Zip Code

_____
Dated

RHODE ISLAND PUBLIC EMPLOYEES'
HEALTH SERVICES FUND
410 South Main Street
Providence, RI 02903
(401) 331-1033

LOCAL UNION 1033/CITY OF PROVIDENCE
LIFE INSURANCE ENROLLMENT/BENEFICIARY DESIGNATION FORM
POLICY NUMBER 4043742

(Please print)

Member's Name:
Last Name First Name Middle Initial

Member's Social Security No.: _____

Member's Date of Birth: _____

Member's Address:
Street City/Town State Zip

Beneficiary Designation: Relationship to Union Member_____
Last Name First Name Middle Initial

Beneficiary Designation: Relationship to Union Member_____
Last Name First Name Middle Initial

Beneficiary Designation: Relationship to Union Member_____
Last Name First Name Middle Initial

Please check one: New Enrollment _____ Change of Beneficiary_____
Change of Name*_____ (*former name_____)

Unless otherwise provided, where two or more beneficiaries are named, the proceeds shall be paid in equal shares to the named beneficiaries, if surviving the insured, or to the survivor or survivors. If no beneficiary survives, payment shall be made in accordance with the terms of the policy.

This designation revokes any and all previous designations. The right to further change the beneficiary is reserved unto the insured.

I accept the insurance provided by my Union's Group Insurance Plan.

Signature _____ Date _____

RETURN TO THE UNION OFFICE

The City of Providence
Providence City Hall
25 Dorrance Street
Providence, Rhode Island 02903

Main telephone number (401) 421-7740
TDD 401 751-0203

www.providenceri.com

Regular Business Hours 8:30 AM to 4:30 PM
Summer hours (July & August) 8:30 AM to 4:00 PM

Orientation sheet Union employees

Vacation

An employee accrues 5 days vacation after 6 months.
An employee receives an additional week of vacation on their 1st year anniversary.
After one year of service, employee receives vacation accrual every January.

After 5 years of service, employee accrues an additional 5 days on the anniversary date. (3 weeks total)
After 10 years of service, employee accrues an additional 5 days on the anniversary date. (4 weeks total)
After 15 years of service, employee accrues an additional 5 days on the anniversary date. (5 weeks total)

Sick Leave

An employee accrues 1 ¼ days (8.75 hrs) every month for a total of 15 days annually. Your hire date must be on the 15th of the month or before in order to accrue the 8.75 hours for that month. Unused sick time may be carried over up to 135 days.

Personal days

You are allowed to convert two (2) personal days from your balance of sick day per year.

Floating Holiday

Employees may take three (3) floating holidays per calendar years.

Life Insurance

The Rhode Island Public Employees' Health Service Fund has the group life/AD&D policy with Assurant Insurance Company in the amount of $25,000.

Longevity

Employees hired after October 23, 1999, 7 years of employment, receive a longevity bonus of 4% of their annual salary. This bonus is usually paid in a lump sum at the end of the fiscal year. June 30th.

Longevity formula for employees is as follows:

Years of Service		Annual Percentage Amount
7	but less than 12 yrs	4%
12	but less than 17 yrs	5%
17	but less than 20 yrs	6%
20	or more	7%

Deferred Compensation

The City provides pre-taxed investment opportunities through payroll deduction. The following are participating providers:

NATIONWIDE RETIREMENT SOLUTIONS
William Redihan, retirement Specialist
PO Box 321
Orleans, MA 02653
Business Phone (877)677-3678 Extension 69003
Email: redihaw@nationwide.com

GREAT WEST RETIREMENT SERVICES
Brian Rocha
401-533-1848
(800)-701-8255

ING
Frank Leonard, Local Account Representative
Registered Representative
30 Braintree Hill Office Park
Braintree, MA 02184
Tel.:781-796-9859
Cell:Tel:RI 401-447-4431
Cell: 617-921-7652
Fax:781-796-9392
Frank@heritageretire.com

ICMA CORPORATION
Mike Savage
msavage@icmarc.org

AIG VALIC FINACIAL ADVISORS
1000 Winter Street
Suite 3750 South
Waltham, MA 02451
Glen Archambault (401) 952-5371
glen-archambault@aigvalic.com
Lynn Redding (401)-486-9638 (cell)
Lynn: redding@aigvalic.com

THE HARTFORD
Laura Slaven
Account Representative
(617) 378-4618

GROUP SAVINGS PLUS (HOME & AUTO INSURANCE)

LIBERTY MUTUAL INSURANCE COMPANY

Liberty Mutual makes it possible for City of Providence employees to enjoy discounted benefits on auto, home and tenant insurance, payment through payroll deductions, guaranteed 12-month policy rate, prompt claims insurance and 24-hour emergency roadside assistance.

Broker: Steven Moran, Roy Jann
Bottom Line solutions
1445 Wampanoag Trail, Ste 105
East Providence, RI 02915-1203
Business Phone (401) 433-1445
Moranis@aol.com
Call for free coverage and no-obligation quote : 1800-225-8281 or visit www.libertymutual.com

Payroll

You will receive your paycheck Bi- weekly. Your paycheck is delivered to you by your department Payroll Administrator on Thursday afternoon.
If you choose the direct deposit option, it will take approx three weeks for the initial request to be processed. The money will appear in the account of your choice (checking/savings) on Friday mornings after 7:00 A.M. You may choose up to 3 banking institutions to divert your paycheck providing the deposit equals 100% of your weekly net payroll amount.

Medical Coverage

You will begin coverage of benefits the 1st day of the month following your date of hire.

Medical Provider: Blue Cross Blue Shield of RI Blue Chip and Delta Dental Provider: Delta Dental of RI.
Website Blue Cross: www.bcbsri.com
Website Delta Dental: www.deltadentalri.com

Pension

The City of Providence deducts an 8% pension contribution.

Leave of Absence/Maternity Leave

Upon written application, an employee with permanent status may be granted a leave without pay not to exceed one year for reason of personal illness, disability, maternity leave, or other reason deemed appropriate and approved by the Human Resource Director.
Please contact Francis Gutierrez in the Human Resource Dept. ext 244.

ING-FINANCIAL

*Effective July 1, 2008 new employees shall **no longer** receive Retiree Post Medicare health benefits paid for by the employer, but the employer shall allow said employees to purchase Post Medicare eligible healthcare at the retirees cost and at the employers group rate. **Said employees shall be require to participate in a Health Savings Account (HAS) at a rate of $.05 per hour with the fund being used for said Retiree Post Medicare healthcare.**

***NEW HIRES SHALL BE COMPENSATED AT A WAGE RATE OF FIFTEEN PERCENT (15%) BELOW THE CONTRACTUAL RATE FOR THE PERIOD OF JULY 1, 2011 TO JULY 1, 2014. WAGES FOR NEW EMPLOYEES SHALL BE INCREASED IN FIVE PERCENT (5%) INCREMENTS ANNUALLY UNTIL JULY 1, 2014 AND ON THIS DATE THE NEW EMPLOYEES SHALL RECEIVE THE FULL CONTRACTUAL RATE.**

General Contact Information

Topic	Contact	Phone/e-mail address
Labor Relations/Employee Relations	Sybil Bailey Director of Human Resources 4th floor Room 401	401-421-7740 ext 617 Assistant Jennifer Conrad Jconrad@providenceri.com
Labor Relations/Employee Relations, Worker's Compensation	Steven Rotondo Deputy Director, HR 4th Floor, Room 401	401-421-7740 ext 616 mwingate@providenceri.com
Training Coordinator	Michael Welden Human Resources 4th floor Room 411	401-421-7740 ext 397 mwelden@providenceri.com
Entrance paperwork, sick, vacation longevity	Diane DiGiuseppe Human Resource Technician II 4th Floor, Room 411	401-421-7740 ext 239 **Fax#273-9510** ddigiuseppe@providenceri.com
Postings	Ebony Palmer Room 411 Human Resource Technician I	401-421-7740 ext 240 epalmer@providenceri.com
General payroll issues	Lori Lazzarecshi Payroll Supervisor 2nd floor School Department 797 Westminster Street Providence, RI 02903 or	Lori Lazzareschi 401-278-0583 Lori.Lazzareschi@ppsd.org
Manager of Employees Benefits	Margaret Wingate Benefits Department Room 410	401-421-7740 ext 717 MWingate@providenceri.com
Medical Benefits Administration	Susan Brophy Benefits Department 4th floor, Room 410	401-421-7740 ext 278 sbrophy@provideneri.com
Pension & Retirement Issues	Marilyn Schoening Pension Administrator 4th floor, Room 409	401-421-7740 ext 296 Mschoening@providenceri.com

PARTICIPATION AGREEMENT FOR THE DEFERRED COMPENSATION PLAN

ESTABLISHED BY THE CITY OF PROVIDENCE

Participant Name (PRINT) First_____ M_____ Last _____

Social Security Number _____-_____-_____

1. Participant Agreement

I wish to participate in the Deferred Compensation Plan and I hereby agree to contribute at the rate of $0.05 cents per hour to be invested in my account with ING Life Insurance And Annuity Company.

In addition to the above mandated contribution, I hereby elect to have an additional contribution of

(Optional: Additional weekly contribution - check one):

____$10 ____$15 ____$20 ____$25 ____Other Amount

I understand that I may change the contribution amount at any time by submitting a new agreement or by requesting a change in another format acceptable to my employer.

2. Beneficiary Election

I wish to designate the following beneficiary(ies) to receive benefits in the event of my death. Primary Beneficiary

Please indicate name(s), relationship, address, percentage)

PRIMARY	CONTINGENT
_____	_____
_____	_____
_____	_____

I understand that benefits are only payable due to Separation from Service, Retirement, Severe Financial Hardship or Death. Furthermore, I acknowledge receipt of, or have reviewed a copy of, the Plan document/or summary plan description, where applicable.

Participant Signature_____ Date_____

3. Employer Use Only

Employee Dept._____Position_____By_____

Number_____SSN#_____Title_____Date_____

Data Requests of the
Division of Public Utilities and Carriers
Set 1

DIV 1-24. Please provide a breakdown of regulatory and rate case expense for FY 2010, FY 2011 and FY 2012 and show the derivation of the pro forma expense amounts shown on Schedule HJS-S7.

Answer: See below an explanation of how the regulatory and rate case expense were calculated for the pro forma year verses the 6/30/12 test year. Also, attached are the regulatory and rate case expense detail from Providence Water's Annual reports for Fiscal Year's 2010 – 2012.

	6/30/12	Pro Forma	Increase	Explanation of Increase
Regulatory Commission Expense:				
Docket 4061/Conservation Rate Filing	8,527	8,593	66	
Bond Filing/Bond Refunding	10,091	10,596	505	Estimate 5% increase
Bond Filing $33 million	0	6,500	6,500	Anticipated based on previous filing
Regional Water District	9,151	9,609	458	Estimate 5% increase
Hydrant Fees	8,603	9,033	430	Estimate 5% increase
New Headquarters	2,068	2,171	103	Estimate 5% increase
Miscellaneous Legal Matters	9,204	9,665	460	Estimate 5% increase
Miscellaneous PUC Matters	11,834	12,426	592	Estimate 5% increase
Proportionate Share PUC Expenses	167,992	202,289	34,297	Use FY 2013 actual amount
Sub-total	$ 227,469	$ 270,880	$ 43,411	
DK 4406				
Full Rate Filing		101,415	101,415	Based on contract plus additional items
Legal		73,632	73,632	Amount based on last full/Conservation filing amount with an 8% increase in contract
Division of Public Utilities estimated		58,575	58,575	Amount based on last full filing amount with an estimated 5% increase
Total Estimated Rate Case this filing		$ 233,622	$ 233,622	

Div 1-24.

Name of Respondent	This Report is:	Date of Report (Mo, Da, Yr)		Year of Report
Providence Water Supply Board	(1) _x_ An Original (2) ___ A Resubmission	2/17/12		06/30/10

REGULATORY EXPENSE AND RATE CASE COSTS (53200)

1. Please provide detail for rate case and regulatory expense for prior 5 years.
2. If there are any open cases before the Commission or Division, they should be noted as such and total costs estimated.
3. Use explanation page to expand description or special circumstances.

							Source of Cost Matrix			Allocation and Distribution		
Description of Rate Case	Docket Number	Requested Amount	Granted Amount	Effective Date	Accounting Fees	Counsel Fees	Outside Consultant	Other	Total Cost	Expensed To Cost Centers	Commissi Allowed In Rates	Reserve Bal. if Any Col (j) - (k)
(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)
									0			0
Full Filling	3832					1,229			1,229			0
Printing DK 4061						2,347			2,347			0
Abbreviated filing	4061				18,804	43,375			62,179			0
Conservation Filing	4061								0			0
Miscellaneous PUC Matters:						4,268			4,268			0
General Matters						4,553			4,553			0
									0			0
Metropolitan Water District						14,310			14,310			0
Legislation									0			0
Hydrants						5,325			5,325			0
Bond Filing Stimulus						4,403			4,403			0
Customer Billing Disputes						30,136			30,136			0
Moratorium						1,608			1,608			0
Street Resoration						0			0			0
									0			0
									0			0
									0			0
									0			0
									0			0
									0			0
Proportional Share of PUC Expenses								136,675	136,675			0
Advertising/Providence Journal								4,082	4,082			0
Division share of expences								17,859	17,859			0
									0			0
									0			0
									0			0
Totals		0	0		18,804	111,552	0	158,616	288,972	0	0	0

Name of Respondent	This Report is:	Date of Report (Mo, Da, Yr)		Year of Report
Providence Water Supply Board	(1) _x_ An Original (2) ___ A Resubmission	8/30/11 0:00		6/30/11 0:00

REGULATORY EXPENSE AND RATE CASE COSTS (53200)

1. Please provide detail for rate case and regulatory expense for prior 5 years.
2. If there are any open cases before the Commission or Division, they should be noted as such and total costs estimated.
3. Use explanation page to expand description or special circumstances.

							Source of Cost Matrix			Allocation and Distribution		
Description of Rate Case	Docket Number	Requested Amount	Granted Amount	Effective Date	Accounting Fees	Counsel Fees	Outside Consultant	Other	Total Cost	Expensed To Cost Centers	Commissi Allowed In Rates	Reserve Bal. if Any Col (j) - (k)
(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)
Abbreviated filing (never filed)					6,190	2,588			8,778			0
Full Filling	3832								0			0
									0			0
Abbreviated filing	4061				19,831	793			20,624			0
Conservation Filing	4061				9,080				9,080			0
Hydrant Fees						2,670			2,670			0
General Matters						5,180			5,180			0
Miscellaneous PUC Matters:									0			0
									0			0
Legislation						960			960			0
Metropolitian Water District/Authority						2,333			2,333			0
Bond Filing $35 million									0			0
Customer Billing Disputes						19,556			19,556			0
Moratorium									0			0
Mlogs						2,545			2,545			0
Board of Contract						2,293			2,293			0
Miscellaneous									0			0
Proportional Share of PUC Expenses								154,863	154,863			0
Division share of expences								2,231	2,231			0
Miscellaneous legal matters						4,275			4,275			0
Advertising/Providence Journal									0			0
									0			0
Note: Other represents									0			0
Division & other minor									0			0
expenses									0			0
									0			0
									0			0
Totals		0	0		35,101	43,191	0	157,094	235,387	0	0	0

Name of Respondent	This Report is:	Date of Report (Mo, Da, Yr)		Year of Report
Providence Water Supply Board	(1) _x_ An Original (2) ___ A Resubmission	8/30/11 0:00		06/30/12

REGULATORY EXPENSE AND RATE CASE COSTS (53200)

1. Please provide detail for rate case and regulatory expense for prior 5 years.
2. If there are any open cases before the Commission or Division, they should be noted as such and total costs estimated.
3. Use explanation page to expand description or special circumstances.

							Source of Cost Matrix			Allocation and Distribution		
Description of Rate Case	Docket Number	Requested Amount	Granted Amount	Effective Date	Accounting Fees	Counsel Fees	Outside Consultant	Other	Total Cost	Expensed To Cost Centers	Commissi Allowed In Rates	Reserve Bal. if Any Col (j) - (k)
(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)
									0			0
Full Filling	3832								0			0
									0			0
Abbreviated filing 2013						359			359			0
Conservation Filing	4061				2,745	2,270			5,015			0
Hydrant Fees/filing	4287					8,603			8,603			0
General Matters						7,704			7,704			0
Miscellaneous PUC Matters:									0			0
									0			0
Legislation						230			230			0
Metropolitian Water District/Authority						9,151			9,151			0
Bond Filing/Refunding						10,091			10,091			0
Customer Billing Disputes						63			63			0
Moratorium									0			0
Marchand Investigation						10,109			10,109			0
Board of Contract									0			0
Miscellaneous						4,088			4,088			0
Proportional Share of PUC Expenses								167,992	167,992			0
Division share of expences								3,512	3,512			0
Miscellaneous legal matters									0			0
Advertising/Providence Journal								553	553			0
									0			0
Note: Other represents									0			0
Division & other minor									0			0
expenses									0			0
									0			0
									0			0
Totals		0	0		2,745	52,668	0	172,057	227,469	0	0	0

Data Requests of the
Division of Public Utilities and Carriers
Set 1

DIV 1-25. Please provide any supporting studies or analyses supporting the projected FY 2013 quantities of chemicals used as shown on Schedule HJS-S8A.

Response: Attached is a copy the chemical use projections that had been performed by our plant personnel which was the basis of the FY 2013 chemical use figures presented in Schedule HJS-S8A.

PROJECTION-TREATMENT CHEMICALS – July 2012 – JUNE 2013

INCREASED FERRIC DOSE NEEDED FOR TOC REMOVAL REQUIREMENTS

CURRENT DOSE IS 2.20 GPG (double previous use) WHICH @70 MGD FLOW equals 4,000 gallons/day

Supporting calculation: (4,000 gal/day x 365days x $1.40/gallon) = $2,044,000.00

ADDITIONAL LIME IS NEEDED TO OFFSET THE INCREASED ACIDITY OF THE WATER DUE TO THE HIGHER FERRIC DOSE.

Current combined DOSE IS 1.70 GPG. WHICH @70 MGD FLOW = 17,160

Supporting calculation: (8.6 tons/day x 365days x $212.45/ton) = $673,158.00 Out to bid

Fluoride: Will become about 70,000 Gallons at 70 MGD

Estimated Cost: $2.90/gallon = $203,000.00

Chlorine: 200 tons Estimated cost: $160,000.00

CO2 Estimate 1,000 tons at $109/ton = $109,000.00

Summary	Ferric	$2,044,000.00
	Lime:	$ 673,158.00
	Fluoride:	$ 203,000.00
	Chlorine:	$ 160,000.00
	CO2	$ 109,000.00

THE FERRIC WILL BE LOWERED AS SOON AS TOC REMOVAL REQUIREMENTS ARE MET. LIME DOSE WOULD ALSO BE LOWERED AT THAT TIME.

Data Requests of the
Division of Public Utilities and Carriers
Set 1

DIV 1-26 Please provide actual quantities of each chemical used for each month of 2012 and 2013 to date. Include a copy in Excel format.

Response: Attached are tables showing the monthly breakdown of chemical usage for FY 2012 and FY 2013 to date. Excel versions are being transmitted separately via email.

For: Division Data Request DIV 1-26

PROVIDENCE WATER

CHEMICALS USED SUMMARY FISCAL YEAR 2012					
MONTH	LIQUID FERRIC GALLONS	QUICKLIME POUNDS	CHLORINE POUNDS	LIQUID FLUORIDE GALLONS	CO2 POUNDS
Jul-11	104,521	617,371	38,776	7,089	-
Aug-11	100,470	560,015	36,154	6,257	78,461
Sep-11	92,582	516,396	35,522	5,287	106,024
Oct-11	86,307	466,886	31,598	4,983	88,266
Nov-11	81,067	393,989	25,902	3,919	85,094
Dec-11	83,204	402,498	24,480	3,784	87,015
Jan-12	97,450	440,158	23,772	3,608	83,462
Feb-12	97,853	473,014	17,962	3,942	84,345
Mar-12	93,329	409,004	20,711	3,872	85,671
Apr-12	85,122	402,069	28,533	3,872	92,892
May-12	95,448	502,599	27,110	4,603	105,199
Jun-12	96,326	483,302	36,075	5,181	115,298
TOTAL	1,113,679	5,667,301	346,595	56,397	1,011,727
	1,113,679 GALLONS	2,834 TONS	173 TONS	56,903 GALLONS	506 TONS

CHEMICALS USED SUMMARY FISCAL YEAR 2013					
MONTH	LIQUID FERRIC GALLONS	QUICKLIME POUNDS	CHLORINE POUNDS	LIQUID FLUORIDE GALLONS	CO2 POUNDS
Jul-12	108,027	587,582	46,262	6,005	136,418
Aug-12	92,780	555,762	49,145	5,317	95,050
Sep-12	76,286	451,299	40,446	4,752	72,851
Oct-12	67,920	409,789	39,296	4,103	58,033
Nov-12	62,684	346,419	25,479	3,683	78,553
Dec-12	62,314	344,288	25,188	3,731	85,426
Jan-13	63,908	347,493	25,588	3,569	87,866
Feb-13	56,831	284,195	22,183	3,169	47,983
Mar-13	60,801	314,027	26,346	3,417	44,164
Apr-13	62,296	283,463	26,452	3,451	-
May-13					
Jun-13					
TOTAL	713,846	3,924,317	326,385	41,198	706,344
	713,846 GALLONS	1,962 TONS	163 TONS	41,198 GALLONS	353 TONS

Data Requests of the
Division of Public Utilities and Carriers
Set 1

DIV 1-27. Please provide a comparison of the actual quantities of chemicals used in FY 2013 to date with the expected or budgeted level to date based on the projected quantities shown on Schedule HJS-S8A and explain any variance.

Response: Due to temporary internal PW issues, a delay has been experienced in obtaining this information. We are in the process of completing this data request and will be forwarding it to the Division as soon as practical.