

REQUEST FOR HEALTH INSURANCE CREDIT

VIRGINIA RETIREMENT SYSTEM
 P.O. Box 2500
 Richmond, Virginia 23218-2500
 Toll Free 1-888-VARETIR (827-3847)
 Fax 804-786-9718
 www.varetire.org

1. Social Security Number
2. Daytime Phone Number
3. Reason for Request <input type="checkbox"/> New participant <input type="checkbox"/> Change in health insurance premium or policy

Complete this form to request a health insurance credit or to notify VRS of changes to your insurance coverage and/or premium amount.

PART A. RETIREE INFORMATION (Please print)

4. Name	(First)	(MI)	(Last)	(Jr./Sr.)
5. Address	(Street)	(City)	(State)	(Zip+4)
6. Are you covered by Part B of Medicare?				
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes: a) Enter the effective date of Medicare: _____ (mm/dd/yyyy) b) Enter the current premium amount: \$ _____/month				

**If you do not have insurance other than Medicare, continue to Part D of this form.
 To report other insurance policies, continue to Part B.**

PART B. INSURANCE POLICY INFORMATION

If you have health, dental, vision, or prescription drug insurance, complete boxes 7-9 about that policy.

7.	If the policy is a Commonwealth of Virginia (COVA) Health Benefit Plan, enter the plan name: _____	
If not, enter the following information from the current health insurance card:		
Plan Name: _____	Membership Type (Choose one):	
Address: _____	<input type="checkbox"/> Single <input type="checkbox"/> Two People <input type="checkbox"/> Family	
_____	Policy Number: _____	
8. Premium Information		
a) How many times per year is the insurance premium paid?	_____	
b) How much is each premium payment?	\$ _____	
c) How much of each payment pays the retiree's portion of the coverage?	\$ _____	
d) What is the effective date of this premium amount?	_____	
9. Cancellation Date of Previous Policy (If applicable) (mm/dd/yyyy)		

10. SSN

PART C. INSURANCE POLICY INFORMATION – ADDITIONAL POLICY

If you have health, dental, vision, or prescription drug insurance other than the policies listed in Part A or Part B of this form, complete boxes 11-13 about that policy.

11. Enter policy information from the current health insurance card for policies other than those listed in Part A or B:

Plan Name: _____

Membership Type (Choose one):

Address: _____

Single Two People Family

Policy Number: _____

12. Premium Information

a) How many times per year is the insurance premium paid? _____

b) How much is each premium payment? \$ _____

c) How much of each payment pays the retiree's portion of the coverage? \$ _____

d) What is the effective date of this premium amount? _____

13. Cancellation Date of Previous Policy (If applicable) (mm/dd/yyyy)

PART D. RETIREE CERTIFICATION

I understand that I am responsible for repaying any overpayment of the health insurance credit. VRS may invoice me for the overpayment or recoup the amount from my VRS retirement benefit. In addition, I understand, upon my death or claim for accelerated life insurance benefits, that any remaining balance will be recovered from the proceeds of my group life insurance coverage. VRS may also recover the overpayment from any refund of retirement contributions and interest payable upon my death. I certify the information I have provided on this document is true, and I understand that any willful falsification of facts presented may result in prosecution for a Class I misdemeanor as provided by law. I also understand that I must immediately report any change in health insurance coverage to VRS.

Retiree Signature

Date

INSTRUCTIONS FOR COMPLETING THE REQUEST FOR HEALTH INSURANCE CREDIT

You may need to complete additional forms if you are making changes on policies with different effective dates.

Part A. Retiree Information

Boxes 1-5: Enter your personal information.

Box 6: If you are covered by Medicare, choose Yes and include the effective date of your Medicare Part B coverage and the premium amount you pay each month.

Parts B and C. Insurance Policy Information

If you have health, dental, vision, or prescription drug insurance, complete Part B. If you have more than one policy, provide the additional policy information in Part C.

Note: Policies *not* eligible for reimbursement include long-term disability, home health care, long-term care, dread disease (such as cancer), hospital indemnity or policies that restrict payment of benefits that treat specific illnesses.

To complete Part B (and Part C), enter the following information from your policy. (Do not include information from policies that are no longer in effect or that are not eligible for reimbursement.)

Box 7: If your policy is an employer-sponsored Commonwealth of Virginia (COVA) Health Benefit Plan administered by the Department of Human Resource Management, enter the plan name.
(Example: Advantage 65)

If your policy is not a COVA policy, use your current insurance card to enter the name and address of the provider, the membership type you selected, and the policy number.

Box 8: Answer the four questions about the premium that is paid for the insurance policy in Box 7. Indicate the number of times each year you pay the premium, the total amount of each payment, how much of that amount is for your portion of the policy, and the date when this premium amount became effective.

Box 9: Enter the cancellation date for the previous policy used to determine your health insurance credit if it applies.

(If you have a secondary medical insurance policy, complete Part C in the same manner as Part B.)

Part D. Retiree Certification

Sign and date in Part D after reading the certification statement. Send the completed form to VRS at the address on the top of the form. VRS will retroactively reimburse up to a maximum of 12 months from the date the completed form is received by VRS as long as the necessary health insurance information is provided. VRS is required by law to send all plan participants an annual reminder to keep their health insurance coverage information current.

Completing Part A: Retiree Information

4. Name	(First)	(MI)	(Last)	(Jr./Sr.)
John Member				
5. Address	(Street)	(City)	(State)	(Zip+4)
12345 Some Street, Richmond, VA 23218				
6. Are you covered by Part B of Medicare?				
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
If yes: a) Enter the effective date of Medicare: 07/01/2008 (mm/dd/yyyy)				
b) Enter the current premium amount: \$ 222.22 /month				

This is the date you started receiving Medicare.

This is the amount you pay each month for your Medicare Part B coverage.

Completing Part B (and Part C): Insurance Policy Information

7. If the policy is a Commonwealth of Virginia (COVA) Health Benefit Plan, enter the plan name:	

If not, enter the following information from the current health insurance card:	
Plan Name: Blue Cross Blue Shield	Membership Type (Choose one): <input checked="" type="checkbox"/> Two People
Address: 9876 Other Street	<input type="checkbox"/> Single <input type="checkbox"/> Family
Richmond VA 23219	Policy Number: 123456789
8. Premium Information	
a) How many times per year is the insurance premium paid?	12
b) How much is each premium payment?	\$ 350
c) How much of each payment pays the retiree's portion of the coverage?	\$ 175
d) What is the effective date of this premium amount?	09/01/2008
9. Cancellation Date of Previous Policy (If applicable) (mm/dd/yyyy)	

This indicates the number of people covered by your insurance.

This is how much you pay for the insurance (not including any amount your employer may pay).

This is the date the premium became the amount entered in 8.b.

If you selected a Membership Type of "Single," then 8.c. is the same amount you entered in 8.b.

If your Membership Type is "Two People" or "Family," then this is the portion of the amount written in 8.b. that pays for *your* coverage. For instance, you may have selected coverage for "Two People" and pay \$350 per month, but only \$175 of the premium goes toward paying for your portion of the coverage. In this case, \$350 is reported in 8.b. and \$175 is reported in 8.c.